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Courtesy of "All the Children"

EDUCATION NEVER CEASES

SEPTEMBER is here again. Janitors open up buildings; teachers and nurses plan their work; mothers and fathers buy clothes; and children go to school. But education is not beginning again after a three-months' vacation. Oh, no! Education goes on, in school and out, winter and summer.

During vacation months some children learned from a trailer about the country in which they live. Some learned in summer camps what woods and fields and starry nights could teach them. Others were taught new and often undesirable things on the street. Some had physical examinations and correction of defects in preparation for the coming year. Some learned to play new games, and got brown skin and firm muscles. Others learned in crowded rooms or streets to daydream or find excitement in lurid tales, because they knew of no other recreational activities. Yes, education went on. Education does not cease for the child when he goes home at three o'clock or when school is closed for a holiday.

How may the school nurse have a part in providing opportunities for children to learn desirable health practices and attitudes through experiences outside the school? Here are a few suggestions:

She may plan with the parents, in-

dividually and in groups, for using community facilities—parks, libraries, Y.M.C.A., Y.W.C.A., playgrounds—for wholesome recreation after school, over week-ends, and during holiday times.

She may assist the school authorities to provide health supervision as well as play supervision for community playgrounds.

She may learn about home and community conditions which affect the lives of the pupils, and may interpret these conditions to the school. Her contacts with other social and health workers are invaluable here.

She may advise on the health- and safety-supervision of athletic events, hikes, camps, winter and summer sports, and other recreational activities.

She may learn and interpret the laws which govern the working hours and conditions of children in the community.

She may help to arrange extracurricular activities to meet the individual needs of pupils—clubs, hobbies, handicraft skills, dramatics—both inside and outside of school.

She may see that lists of movies approved for children are posted where pupils and parents have access to them.

She may help to plan informal parent-study groups on child health and development.

She may work to secure provision for medical care, and for the education of pupils and parents in physical and mental health. Here she may function as a member of a council of social agencies or similar group—or even in an informal conference group of community health workers.

She may give pupils, teachers, and parents simple instructions regarding first aid and accident prevention at home and on the highways. This teaching may be done in coöperation with the American Red Cross and other local agencies such as the Boy Scouts, Girl Scouts, and Campfire Girls.

These and many other ideas will be carried out by the school nurse who has the vision to realize that only through considering the child in all his contacts in the home and in the community can health education be really effective in influencing his habits and attitudes. V.J.

THE MALNOURISHED CHILD

THE NEW EMPHASES in determining nutritional status are brought out in two book reviews on page 554. Research has shown that the use of height-weight norms is not an accurate guide in estimating nutrition, and that a single medical examination—however complete—is not a reliable means of rating nutritional status. The doubtful value of nutritional surveys is also indicated by these studies.

What, then, should be the emphases in nutritional programs? First, a complete and continuous record of the child's development, health history, and family history is of paramount value in determining nutritional status. The nurse and teacher can often help in securing this record. Second, the regular health supervision of the child by a physician gives a more accurate picture of his condition than periodic examinations without continuous medical records.

Finally, stress should be laid on the child's *growth* rather than his weight in comparison with a so-called norm based on an average which does not take into account individual differences in maturation and body build. The monthly weighing of children is still encouraged as an educational device to interest the child in sound health habits. The selection of children who have failed to gain for each of three successive months is suggested by some authorities as a screening procedure to discover those in need of individual attention.

Helping the Teacher with Health Education

By RUTH E. GROUT

Health service, health instruction, and healthful school living are all considered a part of health education in the schools, and to each of these the nurse makes a contribution

THE PUBLIC HEALTH NURSE, especially in rural areas, often is called upon to assist in school health education. With the many ideas and practices that exist today in relation to health education she frequently becomes puzzled to know which of them she may accept and which she may apply effectively in her contacts with the schools.

The success of her contributions will depend upon a number of factors, including the readiness of the teachers or the administrators for new ideas, and her own preparation for imparting them. This article offers suggestions to the nurse who may be given a chance to help, and who wishes to make the most of her opportunities.

GAINING NEW UNDERSTANDING

A first step in approaching school health education is the development of a sound point of view toward the whole field of education. No one knows better than the nurse that the receptiveness of school people toward suggestions for health education activities is often dependent upon her own understanding of educational problems.

Dr. Frederick G. Bonser once said, "The purposes of life, health, and education are one, the end and aim of all are growth and the enrichment of human experience."* Educators today are concerned with the problem of bringing about the optimal development of the whole child through many and varied experiences. In health education this means that they will seek to give the child opportunity for and encouragement in healthful living through the day, and an appreciation and understanding of health principles at his own level of comprehension. They will attempt to build on his interests and needs. They are one with health workers in wishing him to be an individual capable of caring for himself—including his own health—and of protecting the health of others. In this broader interpretation, health services, healthful school living, and health instruction are considered a part of health education.

For the nurse who would like to enlarge her background there are a number of sources to which she may turn. A review of the excellent articles on school health which have appeared in PUBLIC HEALTH NURSING during the past two years will do much to organize her thinking in regard to the newer philosophy and methods in this field. Lists of books on modern education which can be read with profit may be obtained from state departments of education and from local school people.

The nurse who seeks assistance from her school principal or superintendent for a better understanding of the purposes and problems of the local school system has gone far in extending her future usefulness. She may request the privilege of attending an occasional teachers' meeting to gain a better grasp of what the teachers are thinking or

*Bonser, Frederick G. An Educational Perspective on Health Teaching. Reprinted from School Health Progress, American Child Health Association, Sayville, N. Y., June 17-22, 1929. Page 315.

doing. She may ask for a suggested reading list, or for a loan of books or articles which have local value. The school administrator will have copies of state or local teaching guides in various fields of subject matter with which the nurse should be familiar. From him may be obtained the addresses of educational groups on whose mailing lists her name should be included. A knowledge of his slant on education will be helpful to prevent possible misunderstandings. And surely an appreciation on his part that the nurse is interested in more than health protection will be an asset.

Many state departments of health and departments of education now employ consultants in school health education who will gladly help the nurse in planning her work with schools. They may be able to visit her upon request and study the local situation with her, thus enabling her to bring her health program into line with state and local policies.

DETERMINING THE NEEDS

Equipped with understandings such as those suggested above, the nurse is ready to go ahead. She will have acquired a realization of her own potentialities and limitations and will attempt to offer help only in the directions where she is certain of her ground. She will see chances for making educational use of the medical examination, the correctional program, and communicable disease work. She will notice school environmental conditions that need improvement and will be aware of the opportunities they offer for educational growth. She will learn to depend upon her educational coworkers for determining the methods of meeting health problems through classroom instruction, but will give them invaluable assistance in deciding upon the problems that need first attention.

The nurse's first task is that of transforming passive interest into an active desire to obtain results. The use of survey material often helps greatly in arousing the interest of administrators or teachers in local pupil, school, or community health needs.*

If a survey is to be made, the nurse should stimulate the production of the material locally if possible, perhaps through the assistance of a teachers' committee. The principal or superintendent should help in the selection of teachers for such a committee and should be a member himself. The nurse will be an important member who can provide technical information on health problems.

The experience of preparing such a form as a joint project is well worth the necessary time and effort. Problems become more clearly defined when seen through the eyes of both teachers and nurse, and working relationships may become established on a firmer basis. The form itself, if carefully organized, will have greater weight with other teachers in the system than a survey prepared outside the school system.

A note of warning in regard to the use of terms may be of value. Sometimes the word *survey,* along with other frequently used words such as *questionnaire, units,* and the like, meets emotional resistance. The nurse is wise who selects her terms carefully and refrains from using any one of them too frequently until she is certain it is emotionally acceptable to the individuals with whom she is working.

When the survey is completed it may

*The following sources are offered as suggestions for surveys:

Health Teaching Activities in Rural Schools. Buffalo Tuberculosis Association, Buffalo, N. Y., 1938, pp. 42-46.

Grout, Ruth E. Handbook of Health Education. Doubleday, Doran and Company, Garden City, N. Y., 1936, pp. 34-48.

Rogers, James Frederick. Safety and Health of the School Child—A Self Survey of School Conditions. Circular No. 65, U. S. Office of Education. Superintendent of Documents, Washington, D. C., 1932.

Strang, Ruth M. Every Teacher's Records. Bureau of Publications, Teachers College, Columbia University, New York, N. Y., 1936.

be put in the hands of teachers to use with their pupils as a part of the regular class work. The nurse may suggest to the teachers that they and their pupils adapt the survey to their own purposes, or that it serve as the basis for a pupil-made survey.

After the study of local conditions has been made with the assistance of the survey, the nurse may encourage teacher and pupils to select a few of the outstanding problems for further attention during the year. Even though the nurse may subtly suggest possibilities, for obvious reasons it is better to make the teacher and pupils think the decision is theirs.

Two common problems and ways in which nurses may help the schools meet them are discussed below. They illustrate methods of approach which may be used in meeting other problems. The ideas for the nurse's part should be considered suggestive only, since each situation is unique in itself and the nurse must make adaptations as she goes along.

MEETING NUTRITIONAL NEEDS

Despite the emphasis that has been placed on good nutrition, the problem of adequate diets looms large in most communities. For years to come economic conditions, ignorance, racial food habits, and other factors will mean the lack of proper food for many of our children. Conditions often are depressing, but experience shows that a continual educational program in the schools and in the homes may bring improvements.

If the teacher is to be of real service in building better food habits through her health instruction program she should understand the nutritional problems of the families from which her children come. The nurse, who learns of home conditions in a much more intimate way than most teachers can, has a responsibility in sharing with the teacher any information which will be of help.

Many teachers have found the nurse especially helpful in creating community interest in a school hot-lunch program. The nurse can promote the exchange of ideas between schools and can talk about the lunch program in homes. The need of a home vegetable garden large enough to furnish a year-round supply of vegetables may perhaps be put across more convincingly if approached from the standpoint of furnishing food for hot lunches at school.

It is likely that the nurse will be asked by the teacher for literature on nutrition. She may be tempted to give out whatever appears attractive to the eye, but a real service will be performed if she first culls out whatever materials contain inaccurate or biased information. She will move even more certainly if she secures the help of a state or local consultant in health education, or a well trained teacher or principal, to evaluate the material from an educational point of view as well.

A greater discrimination on the part of educators already has improved the quality of classroom health materials in general. We still place too much reliance, however, on health stories and ready-made posters which are apt to take the place of a functioning program. Too many of us still use competitive devices which arouse antagonisms and fears, and frequently become ends in themselves, thus destroying the value for which they were intended.

EDUCATION IN CONTROL OF DISEASE

Year after year, epidemics of the more common diseases persist in our schools, with often little indication of concerted effort on the part of school and health authorities to decrease them. In some states the policy of basing financial aid to schools on attendance figures has led to the vicious practice of keeping children in school regardless of their physical condition. Attendance banners and certificates have been substituted for common sense.

At least one village school seems to have blasted the idea that emphasis on perfect attendance is the only way of keeping up the attendance record. Although good attendance was stressed during the past year, the greatest emphasis was placed on going to school only when fit to do so. The importance of isolation and keeping away from communicable disease areas became common knowledge of parents as well as children. Several cases of communicable diseases appeared, but epidemics were averted apparently due to the careful program of education which went on day by day in a quiet, nonspectacular, but none the less effective manner. The attendance records of the past year reflect this intelligent approach. The final figures actually showed a higher average attendance than in other years under the old approach through stressing perfect attendance.

If a nurse can find one or more schools in her territory that have done intensive educational work in relation to attendance and disease control she has a mine of valuable information to pass on to other schools which may hesitate to take first steps. If none can be found, possibly she may be able to persuade some principal to experiment.

Many teachers are untrained in principles of public health and unfamiliar with common channels for the spread of communicable diseases. In their schools one may still find the common drinking cup, the practice of allowing a child with a cold to remain in school and to mingle closely with other children, or careless habits such as finger sucking.

The public health nurse who has built friendly relations with her teachers may do much to better such practices. Let us imagine what her approach may be in a one-room school which needs better drinking facilities. She enters the room, waits for the teacher to finish the work of the moment, makes a few pleasant remarks to the teacher—perhaps commending her for something that deserves recognition—and then gradually directs the conversation to the problems of greater interest to the teacher at the time.

Perhaps the teacher recognizes the need for improving the drinking facilities and raises some questions of her own. However, it is possible that the nurse herself may find it necessary to lead the discussion into that direction through such comments as: "I noticed Harry took a jelly jar from his desk out to the pump for a drink just now. Does every child have his own glass?" Here is a hypothetical conversation which might follow:

TEACHER: Yes, all except the Jones family, and all four children use the same glass. I'd like paper cups but the trustee says he's spent all the money, so I guess we'll have to wait awhile.

NURSE: It would be nice to have paper cups, but fortunately you can get along with the other cups if there is one for every child and if the children are interested in keeping them clean. The other day I was in a school where the children, as a part of a study of cleanliness, had worked out a new way of storing their cups so they would keep cleaner. They made a cupboard with compartments, one for each child. The name of each child was labeled with adhesive tape on the cup and again on his compartment, so the cups couldn't get mixed. Perhaps a plan like this would encourage the Jones family to bring some extra jars so every child could have a cup of his own.

TEACHER: That's a good idea. But we've got some room on a shelf of that cupboard over there we could use. We've put the glasses in there sometimes but they always seem to be getting mixed up, and I don't like the idea, especially when there are colds around.

NURSE: That's something the pupils might enjoy working out themselves. Sometimes I think that because we know the dangers of using common glasses we take it for granted the children know, too. Have you made any study recently of the way diseases are spread?

TEACHER: No, but we could.

NURSE: The children might enjoy making a room check-up to find possible sources for the spread of disease, either in the schoolroom equipment or in their own habits.

TEACHER: How could I connect that with storing the cups?

NURSE: I see you have some health books, so they could do some research study on the ways diseases spread. Don't you suppose they may hit upon the cup problem themselves? If they don't, I think you'll find some way to get them to. You are all set then to work out with them some better system for storing cups.

TEACHER: That's true. I could remind them that we have some extra oilcloth left over from the desk mats which we made for hot lunches. Maybe they'd find some way to use that.

NURSE: A fine idea. You'll want to lead them to seeing that separate mats for each glass should be used instead of a common mat. I'm inclined to think that turning all the cups over on a single piece of oil cloth or paper toweling is about as dangerous as using a common cup. The water runs from one cup to another so very easily.

I'll be interested to know how you come out with this. My guess is that they will think of things that can be done which neither you nor I have thought of. Maybe you could get them to write me all about it someday. I'd very much like to hear what they finally do.

One may note that the conversation between teacher and nurse centered almost entirely around the children and their activities. The nurse made every use of the teacher's own ideas and supplemented them with pertinent information where it seemed to be needed. She left some specific suggestions, but did not settle anything for the school. She tried to arouse in the teacher a desire to use a similar approach so that the children themselves would make their own decisions, after having gained a background of knowledge.

A nurse may find the opportunity to suggest to her principal or superintendent that someone like herself or the local health officer explain to the teachers at one of their regular meetings the fundamentals of disease control as applied to school health. A carefully prepared talk related to local conditions and an outline of the basic facts to go with the talk should be of considerable help to the teachers.

In a recent health information test given to secondary school students in a rural community, an amazing number of students showed lack of knowledge of the fact that toxoid is given to protect a person from diphtheria. This community is an average one where there has been even more than the usual amount of interest in health education among the teachers. Many of the students as well as their younger brothers or sisters have had the benefits of toxoid treatment. Why, then, should such ignorance exist? No final conclusions can be drawn as to the cause, but one wonders if immunizations and other health services have not been given in a perfunctory manner with little effort made to inform children of their purposes.

In the past we too often have failed to make full use of everyday experiences in our educational programs. The teacher of today, however, is anxious to improve the situation. In the field of health education, the nurse is in an especially advantageous position to bring many vital problems of health into the realm of the school. Her work may supplement that of the teacher, who first of all is responsible for the instructional program.

FOR THE SCHOOL HEALTH EXAMINATION

The schools in one New Jersey city have solved the problem of the children's apparel by asking the children to bring their bathing suits to school for the examination.

This incidentally meets the objections to a stripped examination in school.

A Joint Committee on School Health

By H. D. CHOPE, M.D., M.P.H.

Who shall administer the school health program? The answer of one city is a joint committee representing both the departments of health and education

ANYONE associated with school health service is familiar with the long-standing debate as to who shall administer the school health program—the department of education or the department of health. A complete review of the literature on this controversial subject is not essential to a discussion of how the problem is handled in Newton, Massachusetts. But the opinions of several authorities will show the different points of view.

Both positions are presented by Wood and Rowell. They explain that one group favor administration by the health department because it is the health authority in states and municipalities and its duties therefore include the school health service; while the other group "prefer board of education control because all school matters logically come under educational authorities." These authors also state that "the practice in all except the largest cities is now, and has been since 1911, to favor control by the school authorities in the proportion of about three to one."[1]

Administration of the school health program by the board of education was favored by the committee which prepared the White House Conference report on the school child published in 1932. Since "all phases of the program have important and indispensable contributions to make to the education of the child," the committee thought that "all activities of the program should be under full control of the board of education, with the closest coöperation with other health agencies of the community and state."[2]

An advocate of health department administration is Dr. Wilson G. Smillie, who takes issue with the White House Conference report. He says: "This is so palpably unsound from the point of view of good administrative practice that it is scarcely necessary to argue the point. No one questions the authority of the department of education in relation to the technique of school health education and physical education; but the medical and nursing aspects of school health work represent an integral part of the whole program for the community and are the province of the health department."[3]

A middle ground is taken, on the other hand, by Dr. Harry S. Mustard: "The doctors, nurses, and dentists may be employed either by the department of education or the department of health, more frequently, and perhaps desirably, by the latter."[4]

The need for greater emphasis on the quality of service rendered, regardless of the administration under which it functions, is urged by Dorothy Deming, general director of the National Organization for Public Health Nursing in a recent editorial, "Who Shall Administer School Nursing?"[5]

The city of Newton, Massachusetts, has worked out what appears to be an effective solution to this difficult problem of school health administration.

Newton is a residential suburban city about eight miles from Boston with an estimated population of 75,000

people and a known school population of 14,862 during the school year 1937-1938. The school population is divided as follows: public—12,043, parochial—1954, private—865. In the public school system there are 22 elementary schools, 4 junior high schoools, and 1 senior high school; in the parochial system, 4 elementary schools and 3 high schools.

The school health service in Newton is an old one, and has always been under the direction of the health department. The first school physicians were appointed in 1906, the first school nurses in 1910. A school dental service was established in 1919. The nursing service has been generalized since 1927.

Prior to 1935 the school medical, nursing, and dental services were administered under the efficient but undivided authority of the health officer. Entirely independent of the school health service, the supervisor of elementary education in the schools built up a health education program which attracted national attention.

Between 1934 and 1936 it became obvious to both the departments of health and education that there was urgent need for better correlation between the medical and the health education services. How could improvements be effected promptly with least disturbance to school administration?

JOINT COMMITTEE APPOINTED

At the suggestion of the supervisor of nursing in the Newton Health Department, a joint committee was appointed in 1936 by the superintendent of schools after a conference with the health officer. The committee was made up as follows:

One secondary school principal
One elementary school principal
A member of the department of research and guidance in the schools
The supervisor of physical education in the schools
The health officer
The nursing supervisor of the health department

This original committee drew up a set of objectives to guide their activities. These objectives are:

1. To advise as to how the school health service may become increasingly educational in character.
2. To aid in recognizing the educational possibilities of health service and in utilizing the opportunities offered by it in health instruction.
3. To coördinate the service rendered by teachers, school physicians, nurses, and dentists.
4. To advise concerning the procedures affecting health service and the school program.
5. To publicize among the six hundred odd employees of the school department the objectives and plans of the health department and the committee.

The committee has been expanded to include the supervisor of science and the supervisor of physical education in the junior high schools. Other members of both the health and education departments frequently sit in on the meetings when subjects of special interest to them are to be discussed. Such visitors have included the supervisor of elementary education, the director of the division of research and guidance, the school psychologist, the visiting teacher, the lip-reading teacher, the supervisor of the school census, the chief inspector of the health department, and the chief clerk of the health department.

WHAT THE COMMITTEE DOES

A list of some of the topics which the committee members have discussed will give a good idea of its usefulness:

1. They discussed in considerable detail the physical examination of school children and made definite suggestions for the improvement of these examinations from the educational standpoint and from the standpoint of school administration.*

2. They discussed in detail the health

*See footnote page 511.

examinations for teachers eligible for tenure and laid down policies for the guidance of the health department.*

3. They discussed the advisability of preparing for distribution standing orders on the control and treatment of epidermophytosis in school children.*

4. They studied existing systems of referring pupils to the school physician and devised a card which was printed for experimental use in selected schools. After an experimental period the use of this card was recommended for adoption in all schools.

5. They discussed at considerable length the proposed program for dental health service and made many valuable suggestions for the administration of the program in the schools.

6. They discussed the problem of vaccination certificates and set up policies for the guidance of the school and health departments in controversial cases.

7. They studied the methods of vision-testing in the schools and requested that the health department issue a bulletin describing standard procedures to be followed in detail in all schools.

8. They discussed the program for hearing-testing with the special teacher and designed forms for clearing all referred cases through the health department and the public health nurses.*

9. They collaborated in a study of speech defects in school children and assisted in drawing up a proposed program for the consideration of the school committee.*

10. They investigated the methods of providing first aid for school children, which resulted in the issuance by the health department of a bulletin on first-aid procedures and in the designation by the school of selected, trained individuals on the teaching staff to take responsibility in case of an accident in the absence of the nurse.*

11. They studied the existing methods of weighing and measuring children and set up a guide for a standard uniform procedure in all schools.

12. They discussed the inspection of children by the nurse at several meetings. Many procedures which were of value were interpreted to the teachers, and others which were considered to be unnecessary were discarded.

13. They assisted the health officer in arranging for a detailed examination of all food handlers associated with the school cafeterias.

14. They assisted in planning the health-education campaign which preceded the tuberculin-testing clinic.*

15. They studied several phases of the health-education program in the schools with the goal of designing a working curriculum for health education at various grade-levels.

16. They discussed with the health officer the preschool conferences held for the first time in the fall of 1937. They assisted in publicizing the service through the schools, and offered many suggestions for correlating this work with the school health service.

17. They initiated the idea and assisted in the preparation of a manual, "Looking Forward to School Entrance," for parents whose children were about to enter the Newton Schools.*

18. They studied the procedures associated with the registration of children in school and designed joint forms which would provide the health department with essential data needed by the nurses.

19. They studied in detail the methods of reciprocal reporting of communicable diseases and contacts between the health and school departments and worked out a system acceptable to all so that the information may be relayed with the least possible delay to the nurses, the central office, and the principals and teachers.

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*See footnote page 511.

20. They designed, experimented with, and adopted a classroom summary of physical status for use in teacher-nurse conferences on the findings of the annual physical examination of school children.*

This amount of work has been accomplished during fourteen meetings held monthly during the school year since the committee was organized in May 1936. The accomplishments have been listed more or less in the order of their occurrence. It is obvious that at first most of the thought was devoted to health department problems—such as physical examinations, eye-testing, communicable diseases, dental service, and first aid. But as the work of the committee progressed, more and more subjects related to health education came up for discussion—such as the health education preceding the tuberculin-testing, the dental education program in the schools, the preparation of a manual for new students, and the building of a general health-education curriculum. This last subject has been attacked only as individual projects came up for discussion. But at the last meeting of the committee in May it was agreed that during the school year of 1938-1939 considerable time would be devoted to the general subject of health education.

ADVANTAGES OF JOINT EFFORT

What are the advantages of this type of coöperative administration for a school health services? Here are some of them:

1. All medical, dental, and public health services are under the direction of one administrative unit, so that the school health service is an integral part of the whole program for child health.

2. Only one group of nurses is employed, each nurse handling all problems in the family unit—preschool, school, and adult health, acute communicable diseases, and tuberculosis.

3. There is no duplication of service and there are no crossed wires between public health nurses in the health department and those in the schools.

4. It is the best procedure yet found by the author to assist in making every school health service educational in nature.

5. Such a procedure makes it possible to administer the school health program on a high plane of efficiency at the lowest possible cost as no additional personnel are required to follow out this program.

6. Such a system smooths out many of the administrative difficulties frequently encountered when a health department administers a school health program. The representatives of the various educational groups on the committee—such as the principals of elementary and secondary schools and the science teachers—take back to their respective groups the items discussed in committee and obtain further opinions from the individuals in their schools. These opinions frequently suggest further improvements in procedures. At the same time the school administrators are kept informed of anticipated changes in the school health program.

7. Because of the fact that teachers and principals feel that they have had a part in designing the program, an excellent teacher-nurse rapport and a good relationship between the health department and school department are developed.

8. The plan is unexcelled as a method of developing a sound public health viewpoint on the part of the school personnel on the committee, and reciprocally it provides the health department workers with the educational viewpoint.

*It is not possible to describe in detail the accomplishments listed under these 20 items. However, data covering any item which is marked with an asterisk will be sent upon request to Dr. H. D. Chope, Health Department, Newton, Massachusetts.

THE DEMOCRATIC METHOD

The only disadvantage encountered is that associated with any type of democratic administration, as contrasted with the autocratic or dictator type of administration. The development of a desired program is frequently time-consuming, demanding several committee meetings before the final project is approved. However, this can hardly be considered a real disadvantage. When the idea is complete it is the result of more mature deliberation and the details are much better worked out than if the health officer simply decreed the adoption of a certain procedure regardless of the feelings of the school administrators and teachers who must participate in carrying out the order.

When the appointment of this committee was first suggested, it was considered entirely experimental by both the superintendent of schools and the health officer. After two and a half years of activity it can be safely stated that neither administrator would wish to be without the advice of this joint group. It has not developed into just another committee, but interest has always been maintained at a high level. Meetings are anticipated by each member. All have worked tirelessly, and each member has made many contributions to the success of the school health program. Meetings are held sometimes in the health department offices and sometimes in the schools. Now and then a luncheon meeting is arranged. Discussions are never dull, sometimes even spirited; and the esprit de corps is unexcelled.

Such a coöperative venture seems to be a solution to the long-standing debate over "Who shall administer the school health program?" Our answer is: the health department, with the assistance of an advisory committee made up of representative educators appointed jointly by the superintendent of schools and the director of public health. This may seem to be primarily an administrative problem rather than a nursing problem, but it must be remembered that the idea was initiated by a public health nurse in Newton. The nursing personnel in other cities could easily suggest such a committee where there is need for better correlation of the activities of the school department and health department.

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[2] Report of the Committee on the School Child. White House Conference on Child Health and Protection. The School Health Program. The Century Company, New York, 1932, p. 249.

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[4] Mustard, Harry S. An Introduction to Public Health. The Macmillan Company, New York, 1935, p. 198.

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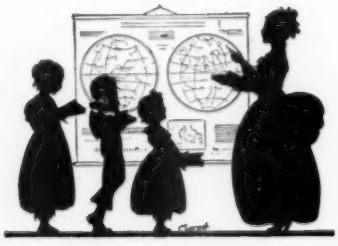

The Child with a Cardiac Handicap

By LOUIS FAUGERES BISHOP, JR., M.D.

All those who care for children should be on the alert for symptoms of chronic rheumatic fever, and every cardiac child should be kept within his individual energy limits

WHEN ONE CONSIDERS that at least 90 percent of all cases of rheumatic heart disease in children result from rheumatic fever, the question naturally arises: How can we stamp out rheumatic fever? Unfortunately, the cause of rheumatic fever is still unknown. At the moment it is believed to be due to some type of the streptococcus.

What we do know about rheumatic fever is that outwardly it is evident in swollen and reddened joints; but it is the inward damage to the heart of the child with which we are concerned. In the acute stage the target at which rheumatic fever infection usually shoots is the heart. Therefore, to save a child's heart from structural damage resultant from rheumatic fever, every possible effort should be made to guard him from contracting the disease. It is known that children living in congested districts under conditions of poverty and bad housing, especially in the cities in northern areas, are more susceptible to rheumatic fever. Little girls apparently have less resistance to the germ than their brothers. Rheumatic fever is not usually considered communicable, but it is frequently observed in several members of the same family.

PREVENTIVE MEASURES

Preventive measures consist in (1) better living conditions, (2) watching the ports of infection—tonsils, teeth, and adenoids—since rheumatic fever is often associated with colds, sore throats, and also so-called "growing pains." And always the public health nurse, the teacher, and the mother should bear in mind that rheumatic fever is chronic as well as acute. Rheumatic fever is a recurring disease; it is unusual for a child to have a single illness. The first five or six years after the onset of the original attack are the crucial ones, so far as the future is concerned, for this is the time when the disease most often recurs, and when cardiac damage most frequently occurs.

The diagnosis of acute rheumatic carditis is usually so obvious that the necessity for bed rest might be likened to the need of a fire-engine and hose to quell a blazing fire. The difficult problem is to educate and train the teacher, the mother, and the public health nurse to recognize the smoldering fire of inactive rheumatic heart disease.

WHAT ARE THE SYMPTOMS?

All those who are responsible for the well-being of children should be on the alert for symptoms of chronic rheumatic fever. Rheumatic fever does not always subside in a few weeks after the acute attack, but may persist for months or years. In many children who ultimately succumb, the disease apparently never becomes inactive. While symptoms may be mild and low grade, they *are* significant. These are varied degrees of joint pain, low-grade fever, rheumatic nodules under the skin, frequent nosebleeds (not related to the bumps of childhood), abdominal or precordial pain, loss of weight, or failure to gain weight. Chorea has a close

association with rheumatic fever. Congestive heart failure in the child with rheumatic heart disease is of course evidence of active rheumatic fever.

The laboratory bears out the significance of these symptoms, described above, which may persist for months or years. Tests of value which the doctor employs, when warned of the symptoms by nurse, mother, or teacher, show an increase in the sedimentation rate of the red blood cells, repeatedly elevated leukocyte counts, and prolongation of conduction time as indicated in the electrocardiogram. These tests, if positive, herald what would seem to be the silent development of or increase in degree of rheumatic heart disease.

When children with the above symptoms attend school, the coöperation of the mother and teacher must be very close, for it is easy to miss the small licks of flame that occasionally flare up in children who have had rheumatic fever. The heart has in nearly every case been affected, and each time there is an onset of temperature the child is freshly endangered. It is better for the child to miss a week of school than a year of the life span. It is well always to remember that "so long as infection is in the body, there is an active fight going on between the body cells and the invading microbes. This places an extra burden on the heart and makes special care and extra rest—sometimes absolute rest—necessary to prevent heart strain."[1] Not only therapeutic but psychological care is necessary for the child with rheumatic heart disease. One day I stood by an old hulk of a tree. For many years the tree had grown in that spot and many a time it had been hit by farm trucks because it was at the sharp turn of the road. Scars innumerable marked its base, and it seemed nothing but a husk. But the top was full of lusty branches full of apples. So it is with the child who is attacked by rheumatic fever. If he survives the reinfections and recurrences, he may grow with surprising grace "at the top." He should not be considered a helpless invalid. The heart may be weakened, but the spirit will be strong if the guiding adults know how to combine psychological and therapeutic care through the periods of stress, the assaults of infection on a heart already handicapped by previous rheumatic battles.

AVOID REPEATED INFECTIONS

In the acute phase of rheumatic heart disease it is obvious that activity must be limited. In the subacute phase it is not so easy to know what to advise, for such children are commonly ambulatory. Laboratory tests are sometimes of little aid. The blood count, for example, may be normal. It is not exercise that brings about a rheumatic cardiac breakdown in a child so much as repeated infections.

Take for instance a boy of sixteen to whom every new infection superimposed on his already scarred heart means danger. The school which he attended was approached to ascertain whether a health inspection of the students is made each day by the teacher or nurse, for evidence of fever, sore throat, or other symptoms of illness. It appears that such a procedure is not routine practice in this school. Yet the boy is not in condition to withstand another infection and some plan for the immediate detection of even minor symptoms of infection is imperative. The teacher should be taught to be alert to warning signs that may indicate a flare-up and to refer the child for immediate medical attention when symptoms appear. A monthly, or even weekly medical check-up is a wise precaution.

While the ideal procedure to safeguard school children with rheumatic fever against the insidious inroads of this disease on the heart might seem to be a daily checking of temperature and symptoms, this procedure is not always

advisable unless it can be done without emphasizing the child's defect. It is always wise to remember that the infection that attacks a child's heart may also have affected his nerves. To routinely take a child's temperature every day may easily lead in itself to neurotic disease self-consciousness. It is up to those who guide the child to make up some thermometer "game" which will without undue emphasis on the child's invalidism spot the deadly presence of rheumatic fever. The programs suggested for teachers in *Hygeia* magazine are admirable for use in this connection.[2]

EXAMINE CHILD AFTER INFECTIONS

It is well to remember that there may be a low-grade active phase of the rheumatic process following not only an acute attack of rheumatic fever, but also frequently following whooping cough, measles, scarlet fever, and similar infections. The only way to be sure that the child is all right is to insist on a thorough physical examination after any infection before he returns to school. To add an active school program to an active disease is courting disaster for the child's heart—and his future.

While it is primarily the doctor's job to recognize the warning signals of active rheumatic infection, he is not always there to see these symptoms. It is therefore a safeguard for the public health nurse and the teacher to be aware of the dangers of the situation. For no child should be tied to the doctor's apron strings any more than to his mother's.

SHALL THE CHILD ATTEND SCHOOL?

In low-grade rheumatic infection the question is often asked whether or not the child should be permitted to attend school. This is an individual matter. Every cardiac child should be protected from inclement weather, and should be kept within his individual energy limits. Foci of infection should be eliminated.

Of course one must remember that the teacher or nurse is bound to encounter a wide divergence of therapeutic philosophy with regard to the treatment of heart disease—and just as wide a divergence of psychotherapeutic philosophy. If she has the good fortune to coöperate with middle-of-the-road medical conservatism, the ideal result may be attained—that of an individual program for every child.

A LONG-TIME PLAN

If the public health nurse, the physician, and the teacher can have the vision of the mother for her child, perhaps a "five-year plan" may be evolved, so that a little time missed from school this year may not matter so much in the long run. When the sun shines on the child with a cardiac handicap and all is well—no fever, no symptoms—then full speed ahead in regard to learning and thoughtfully planned physical activity should be advised. But when it rains on the cardiac child and the fire smolders, it is wise to bank that fire and hold back on mental and physical effort. This will conserve the health of the cardiac child—and preserve the reputation of the physician, the public health nurse, and the teacher.

The heart of a child at birth weighs less than an ounce, but what an important fraction of its weight is that ounce. An adult's heart weighs but half a pound, but what an important half-pound of flesh that is. It is important to prevent any infections that may damage that baby's ounce of heart so that cure will be unnecessary in that adult's half-a-pound of heart. "An ounce of prevention is worth a pound of cure" is truer of heart health than anything else. Rheumatic fever is responsible for such a vast amount of crippling of the heart that we must consider it the leading cause of heart disease in children.

One of the reverberations of the recent National Health Conference in Washington, D. C., was heard in a radio

talk, "The Child Grows Up," by Katherine Lenroot, Chief of the Children's Bureau, U. S. Department of Labor.* Miss Lenroot stated that in northern parts of the country about one percent of all school children suffer from rheumatic heart disease,** and further that unless more comprehensive health programs are developed, many of these children of today will be grown up before anything is done about it.

DAMAGE TO HEART

It should never be forgotten that in children who have had rheumatic fever the heart in ninety-eight times out of a hundred is structurally damaged. Now, overexertion does not damage a normal heart. Nature takes care of us by staging uncomfortable symptoms or unconsciousness. But if the heart is damaged by rheumatic fever, then exertion beyond the child's cardiac reserve may cause untold damage. And in case an infection is present, such as the smoldering fire of rheumatic fever, one is never sure that it may not flare into activity. If unusual effort is allowed at such a time, there is grave danger. The teacher, the nurse, and most important of all, the parent, must be monitors of heart health.

When the heart's structure is damaged, then it is prevented from doing its Herculean task which we so carelessly take for granted. The heart, to be a good pump, must move 500 gallons of blood a day.

"HE WILL OUTGROW IT"

There is one stock phrase that cannot safely be applied to a child's heart if he has had rheumatic fever, and that is, "Forget it, he will outgrow it!" This is far from true, for rheumatic fever, if intermittent, is not conducive to the development of a healthy heart. Rheumatic fever is as degenerative an influence on a child's heart as arteriosclerosis is on the adult heart. Every onset of fever may be the cause of further retrogression in the heart health of a child.

Only recently two examples were noted in activity that was desired by cardiac youths. One boy with a slight cardiac ailment wanted to row in competition at a summer military school. "No," was the answer of the physician. The other boy with congenital heart disease wanted to go to camp. "No, not up to the mark," said his doctor. Home was the best place for him.

No child in whom rheumatic fever is ever suspected should be allowed out of bed while there remains any elevation of temperature. He should be kept in bed until after the temperature has been normal for at least two weeks.

THE VALUE OF REST

Surely rest must be in the forefront of treatment, for we have no other specific measures for care of the acute stage. Whether rest does or does not prevent the development of or increase in rheumatic heart disease, it is generally believed to be of value. Mothers must be versatile in making the days pass interestingly when the child is in bed. The teacher may suggest educational programs and the nurse may initiate health projects. The parents and family may devise new hobbies.[3, 4, 5, 6]

A blanket rule for the child with rheumatic heart disease is to stay away from crowds where minor infections of the nose and throat are more easily passed from one to another, for such a child is susceptible. His defenses are down.

In brief, rheumatic fever is productive of almost all the heart disease which cripples children. The effort to discover the cause, though still un-

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*Station WMAL, Washington, D. C., National Broadcasting Company, July 23, 1938.

**The Need for a National Health Program. Report of the Technical Committee on Medical Care, Interdepartmental Committee to Coördinate Health and Welfare Activities, Washington, D. C., 1938, p. 9.

known, has at least systematized our knowledge. The way lies forward for future advance.

Surely the statistics regarding rheumatic heart disease in children so widely distributed by insurance companies, by the American Heart Association, and by clinics all over the country, portend the importance to American youth of protection from this menace to the heart. The educational health campaign that has done so much for tuberculosis, cancer, diabetes, and anemia should begin to be applied to heart disease.

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SAFETY IN SCHOOL EQUIPMENT

THE HAZARDS arising from neglect of safety measures in schools may be as great as those in industry. Several instances of such neglect are described in the weekly bulletin of the Iowa Department of Public Instruction.

In many manual training shops, table saws are being operated without guards. In some instances the guards are supplied but have been taken off by the instructors. Grinders are being operated without shields or without the use of goggles by the operator. Small particles of carborundum or emery or fragments of steel may fly into the eyes of the operators, thereby causing the loss of sight in one or both eyes. Many shops are permitting jointers to be operated without guards. The students are being permitted to push material through them without the aid of a wooden pusher. None of these practices is permitted in industry.

Another hazard that should be carefully checked is the practice of permitting loose and uncovered electric wiring to exist. Many fires are started as a result, and occasionally someone receives a severe electric shock or burn. Too often someone who knows nothing of the wiring trade or of the code of the Underwriters' Laboratory attempts to do wiring. Only a licensed or experienced electrician should be permitted to make any installations or changes in wiring in a school building.

The blow-off valve on steam boilers is another item in school safety which should not be overlooked. Most school heating plants are of the low-pressure type and the safety valve is set to blow off at from five to twelve pounds of pressure. This valve should be checked occasionally to see that it is not stuck, and at least every four or five weeks the custodian should run the pressure up in the boiler to the point at which it blows off. Steam boilers have terrific possibilities for danger if they are not handled intelligently.

—Condensed from *Educational Bulletin,* Iowa Department of Public Instruction, December 1, 1937.

Adults in the Making

By KATHERINE BROWNELL OETTINGER

The nurse helps the mother to offer the child satisfying experiences in self-help, which give him a feeling of success and lead to ultimate independence

WORKERS in all fields of human relations are constantly reminded that they cannot separate individuals into units neatly labelled *physical, social,* and *emotional.* The effective public health nurse, with her primary emphasis on physical well-being, integrates all three considerations. In infant care, for example, it is no longer enough for the nurse to demonstrate techniques of physiological weaning. She has an obligation to establish a relationship in the mother's thinking between the feeding process and the feeling process. Is it not logical, then, to give the mother an awareness of weaning as the first in a series of steps in which she becomes progressively unnecessary to her child? Her goal is ultimate complete separateness—when her child will be able to live without her, as a self-directing individual. While the nurse is helping the family to conceive of child training in terms of adult outcomes, she may also help them by many practical suggestions in regard to more immediate aims. Thus the mother and the nurse work together with a deep-rooted conviction that their greatest objective is patiently to lead the child from dependence to independence and individual efficiency.

THE CHILD'S INNER SECURITY

The nurse, imbued with the belief that a sense of security must be built up within the child himself, can translate this philosophy to the family so that they may make ingenious, concrete applications from early infancy. The mother learns that the baby first develops a sense of security from the protection of those about him, but that she must consciously help him shift this external security to a security within himself. Gradually she gives him a chance to cope with situations so that he learns he can depend upon himself. His need for protection dissolves into self-reliance by actually accomplishing chores and by censoring and controlling his own behavior apart from adult praise or blame. The checking of a list of the numbers and kinds of habits which a child has developed at any period is insufficient. Has he learned the attitude of coöperation or antagonism as his day-to-day habits form? How does he react to the parents who are guiding him? These by-products either build up or tear down his serenity in regard to his individual safety in a world of complicated demands. The feeling side of life cannot be omitted from health education.

MEASURING CHILD'S DEVELOPMENT

In helping the mother gain a perspective on the child's unfolding steps, the nurse encounters a wide variety of parental attitudes. She finds a mother who is completely lacking in any factual understanding of what to expect at various stages of growth. Many mothers use the unpredictable measuring rod of the child next door or their own ill-remembered development. Here the nurse can dispel uncertainty and confusion. Science has done much to develop an understanding of adjustments

in the mental and social-emotional fields. This understanding gives us an idea of what tasks and privileges come next in order, as the child's capacity increases. The nurse can be most helpful by suggesting to parents that a certain development is *about* what *usually* happens in the orderly growth of the child's skill.

There is a variety of guides which summarize the achievements in locomotion, socialization, and communication[1,2,3] that may be expected of children as they grow older. The most useful of these for application to the ordinary environment is the Vineland Social Maturity Scale, which enumerates performances that are definite products of maturation rather than of formal training. But the zealous nurse must be forewarned. There is no single established march of progress which alone is "normal."

As the child grows, the mother is able to take advantage of his awakening interest in helping himself. It is not difficult to convince the mother of the value of seizing the child's own display of interest as a cue in fostering new fields for independent action. It is the nurse's job to help that mother discover the individual tempo of her own child's rate of development, and select his opportunities for experience in the formation of different habits according to his own balance in physical and intellectual growth. Only as the mother becomes attuned to his rhythm can the child gain that firm foundation of true inner belief in himself. He is accepted at his own level of development, and tastes success in undertakings fitted to his peculiar abilities.

EMOTIONAL OBSTACLES OF MOTHERS

A supply of guideposts does not, however, solve the problem. Much more important are the emotional maladjustments which the nurses encounter, varying between two extremes of reaction: (1) the mother who is compelled to prolong infancy, (2) the mother who is forced to attempt artificially to stimulate adult patterns.

The first mother may possess a good intellectual understanding of mental development and know what to do. But the habits of cradle care hold too much satisfaction for her to abandon them. She enjoys feeding her husky three-year-old; she revels in dressing her five-year-old, blowing his nose, and taking his hand while crossing the street. This kind of treatment produces the common adult problems found in the nurse's daily case load: unweaned grown-ups depending on the nurse for every decision, incapable of taking family responsibilities, emotionally destitute at the loss of a parent; attention-seeking neurotics or suicides.

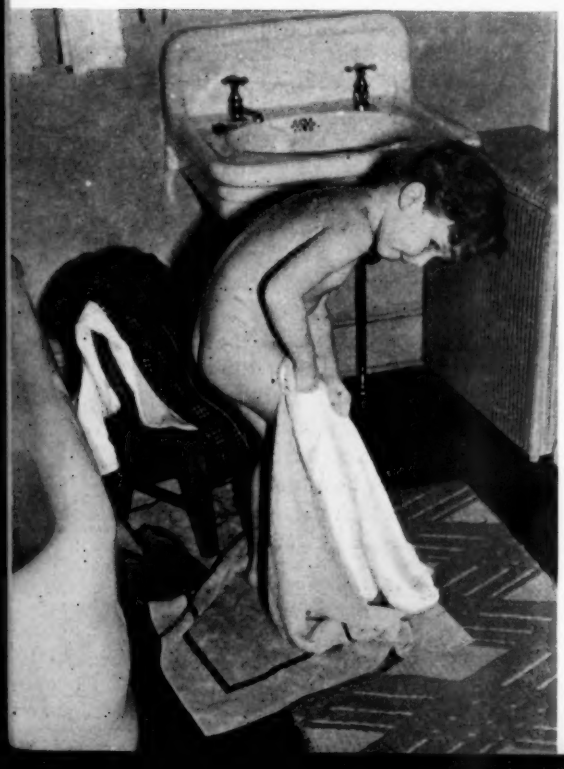
The mother gains insight into laying the foundation of early independence by daily projects in helping the child form elementary habits—which in turn give her actual satisfaction in revising her own habits toward the treatment of her offspring. The nurse may help her consciously to control her impulses toward choking normal growth, and to substitute satisfaction in adapting her care to the child's decreasing needs. The child's early attempts at doing things for himself are not to be recommended as a labor-saving device. But something dynamic in the relationship between nurse and mother may keep the mother learning when and how the helplessness of the child diminishes. And she may increasingly react in accordance with a new-found conviction that the whole process of nurture is "toward the goal of complete self-sustenance of the child at maturity."*

Tense, unhappy, anxious children have led psychiatrists to focus on mothers who, on the other hand, have pushed and pulled their children toward maturity. The nurse can be of real service

*Hollingworth, Leta S. "Parents Must Grow." *Parents' Magazine,* June 1930, p. 49.

Helping little brother dress gives the child a "grown-up" feeling and stimulates him to renewed interest in looking after himself

The two-year-old likes to put away his toys when he can arrange them in spacious cupboards within his reach



Taking a bath is fun when everything is within reach and he can do it all by himself with just a little help from mother on the corners

Shining his own shoes can be a fascinating task which teaches many incidental lessons such as care of clothing, furniture, and rug

Combing his own hair becomes interesting when he has a special mirror hung where he can easily see himself

Managing his own shoes is the most difficult step in dressing, but the child likes the feeling of success in overcoming obstacles

to the conscientious mother who is haunted by a feeling of guilt if her child does not measure up to "standards" on every level. Such an ambitious, aggressive woman frequently provides the kind of home where the nurse feels baffled to make suggestions. The physical surroundings are perfect, the diet faultless, and the regimen strict. The nurse may feel her visit futile unless she recognizes that in the mother's very eagerness to live up to responsibilities, an exacting, strained attitude may be creating emotional problems. The nurse, whom this mother regards as a bearer of standards, may help free the mother from her too-intense need for perfection. In the nurse's own satisfaction at the concrete accomplishments in physical care, she should not lose her vital concern in substituting a better sense of proportion—so that the children may not be clipped into too-standardized patterns.

HAPPY MODES OF EXPRESSION

Pressure on all sides overburdens these mothers with a realization of the significance of basic habit formation in relation to later complex adult behavior. They are going to *make* their children industrious and persevering. Important goals! But not to be superimposed like a new hat or coat. Appreciating the mother's emotional drive, the nurse adapts her teaching to this special need. She does not overemphasize techniques. The mother comes to understand that the child's impetus toward independence must be given happy modes of expression. He must enjoy feeding himself, attempting to dress, and caring for his own possessions. The joy of doing things for himself must not be erased by punishment or reward. The habit of success is the greatest creator. Out of this springs the most valuable of all tools—the ability to acquire new habits with joy and self-confidence. This is adequate training for meeting later emergencies.

Responsibility can only be learned by exercising responsibilities. Precepts are not enough. Experiences develop in many fields. The child's natural interest in the process of dressing, for example, is an asset. The stage has been set even before the baby is born by the nurse's advice in regard to garments which are planned for the mother's ease in manipulating them. During the period of postnatal care the nurse again stresses the elimination of unnecessary handling, so that the child's first experience with dressing is pleasurable. Gradually during the next eight months, the child develops the ability to give attention and then to coöperate actively—lifting up his hands as his shirt is pulled off, helping put his arms into armholes, lifting his feet for stockings or panties, pulling himself up while clothes are fastened, and eventually at about one year of age pulling off his own stockings and shoes. During the next year, he may learn the names of different articles of clothing, bring them to his mother, and help put them away in a designated place.

By the time he has reached the age of two years he is allowed to sit on a low chair where he may grasp and put on his underwear if it is handed to him properly arranged. At first he needs help with guiding one arm so that he may push the other one through the armhole. As he advances he manages the entire process, but he will not be able to handle all the buttons himself unless he has slide fasteners.

By the time he is four years old, he has progressed to taking care of his own suit, except for the back buttons. However, he may practice grasping large buttons and manipulating slide fasteners wherever they are available. So important is the type of clothing which the child wears that the Bureau of Home Economics of the United States Department of Agriculture has made a study of durable self-help garments.[4] Com-

mercial firms have further developed this idea until every department store carries slide fasteners for dresses and outer garments, and clothing with automatic drop seats, adequate openings, and shoulder room.[5] So much of the strain of dressing may be eliminated if the mother is directed to the new type of clothing best suited for self-help. These garments may be purchased ready-made or made at home.

The child can learn early to pull on his stockings if the adult guides the foot into the toe. From the beginning he should be taught to loosen laces of Oxfords. It is helpful to place pieces of adhesive tape on the inner sides of his shoes and rubbers, so that the child can put his shoes side by side and distinguish the left from the right without adult guidance. At about three years of age, he can be taught to straighten the tongue and draw the laces after he has put the shoe on. Tying the bow comes last in dressing skill. Most children cannot be expected to take over completely the responsibility for dressing until they are six years old.

GROWTH PROCEEDS SLOWLY

By a review of these many steps in utilizing the child's willingness to help himself, we can point out to the mother that there is no single age at which he can be expected suddenly to take on the business of self-help in any field. He has always been gradually preparing. Growth proceeds slowly, quietly, consistently. He will show unevenness in mastering the techniques, and the family must anticipate a stage of loss of interest. By the time the child is five years old he is less fascinated by the component parts of dressing. His interest in finishing the job quickly in order to get to more thrilling adventures will help him perfect the activities with which he has had ample experience during the early years. Here is the danger zone where the mother may regress and take over the responsibility or degenerate to perpetual nagging. She must help the child maintain his enthusiasm and overcome these temporary periods of inertia. Simple, efficient methods of arrangements of his clothes include low hooks for hanging, and an individual place for every article helps maintain the dressing process well within the range of his interest and ability.

OTHER FIELDS OF SELF-ACTIVITY

The nurse may stimulate the mother's imagination in regard to other fields of self-activity. For example, the mother may enlist the child's interest in washing to a point where he is capable of taking his own bath by the time he is six years old—with supervision of neglected corners and perhaps some help in drying. A bathroom with low racks may enable him to take care of his own towel and washcloth from about one year of age. A low-hung mirror aids the toddler to wash his own face and later comb his own hair. Brushing his own teeth may be aided by placing two or three homemade wooden steps leading to the basin. These same steps may be shoved over to the toilet in helping the two- or three-year-old manage his own toileting. Setting the stage in the home calls forth the child's own initiative in carrying out routines without direction. His interest in feeding himself may be promoted by letting him pour his own milk from a little jug, by helping him carry his own dishes, and by encouraging the transition from spoon to fork.

Likewise, household tasks offer great satisfaction to a little child, who loves to help in performing such daily chores as wiping the steps. If that task is assigned him, it must be done neatly and well, providing him with a real responsibility for pulling his weight in the boat. Cleaning his own shoes not only offers the child a real job, but makes it necessary for him to keep the rug and

table clean where he is working, and to put away the materials and handle them with care. He can be a real helper in putting away the laundry. Habits of good workmanship flower in such an atmosphere.

It may be the child's job to help dress the younger children in the family. Many a five-year-old has made amazing strides in his own progress when the family has looked to him for the teaching of a younger brother or sister. What an excellent way to build up a happy relationship where friction might exist! Pets and a garden of his own help to crystalize the child's experiences in self-direction. The value of indoor and outdoor play apparatus which calls forth independence, judgment, and courage in manipulation can never be overestimated.

Specific habits give practice in handling situations. Patterns of independence, therefore, are not sudden, volcanic, and unrelated, but they grow as the individual's faith in himself is fortified by experience in self-reliance—experience which is consistent in procedure and regular in performance. What an inspiration the nurse can bring to the financially harassed mother by firing her with the belief that an unhampered environment for genuine growing-up far outweighs any material gifts. In Eve Curie's biography of her mother she comments on Madame Curie's efforts to protect the personality of her daughters from early childhood: "Several things . . . were permanently imprinted upon us . . . an instinct of independence which convinced us both that in any combination of circumstances we should know how to get along without help."[6] Of all the heritage which this illustrious woman left to her children, this impressed her daughter as most important.

NOTE: In an early issue Mrs. Oettinger will discuss the understanding of the child's play-life, as an integral part of the nurse's teaching in the prevention of individual and family problems.

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Changing Health Habits and Attitudes

By ETHEL MEALEY

The most effective method of changing health habits is to learn the needs of the children and to give them experiences in solving their own problems of living

CHANGE, according to common sense as well as psychology, means that there must be a *starting point* and there must be *direction*. Necessarily, then, we have to know our starting point. We must know the pupils whom we are guiding in their daily living; know them not only as individuals, but also as members of various groups. From this starting point we can determine in what direction we wish to move. We must take the pupils as they are and build on that.

FINDING THE HEALTH NEEDS

Our first question is: What methods have proved effective in knowing the pupil; in seeing him in his total environment; in understanding the various factors which have influenced his health, and his attitudes toward health—the influences which have made him what he is at the moment? An answer to these queries was sought by the school personnel and by the writer in several selected elementary and secondary schools in Westchester County, New York.

The first procedure, in the junior high school in Hastings-on-Hudson, was to assemble all available information about the pupils. Valuable data were found in the administrative office, in the files of the guidance counselor, in the office of the nurse, in the physical education department, and in the records of classroom teachers. A study of these data revealed three problems: (1) the need for a simple way of assembling the data for real use (2) the inadequacy of available information suitable for planning a health program (3) the necessity for establishing leadership.

The principal of the junior high school disposed of the third problem by placing the leadership for health activities with the director of guidance. He considers that:

> Until such time as our community can afford additional health teachers, the office of guidance director seems to be the best place to centralize responsibility for guiding health habits and giving information pertaining to health services. Due to the contacts which this officer has with all departments of the school—physical education, household arts, science, health, attendance, and child guidance clinic—responsibility for accounting for the factors pertaining to the health of a student can be centralized and there are not the usual neglect and ineffectiveness which occur when each department assumes some responsibility and has but a vague notion of what the other departments are doing.*

The second problem, that of securing necessary information about the pupils, was approached through group meetings of school personnel in an effort to determine (1) what information about a pupil is essential in planning a health program (2) how this information may be secured (3) how it may be recorded (4) how it may be used.

The consideration of this problem by the group had several outcomes. It resulted in a more comprehensive appreciation of pupil health needs; changes

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*Meyers, Theodore R. "A Comprehensive Junior High Program." *The Journal of Health and Physical Education,* November 1937, p. 542.

in the health examination; changes in the use of the health examination; the preparation of a guide for teacher observation of individual pupils, and of a home inventory; plans for home visits; and the selection of available objective tests.

The study of the data which were needed also put added emphasis upon the first problem, a simple way of assembling and recording individual data for real use. This problem was met through the preparation of a cumulative interpretative record card for planning an individual health program. The card is based upon certain fundamental convictions regarding health, guidance in healthful living, and pupil participation in health practices:

1. The pupil must be considered not only as an individual with his strengths and weaknesses, but also as an individual in relation to all of the many factors which have and are influencing his health and conditioning his health attitudes and health behavior.
2. Pupil records must be cumulative in order to insure consistency and continuity in guidance and in pupil growth.
3. Pupil records, containing essential information for understanding the pupil, should be simple, complete, easily interpreted, and free from unnecessary duplication and clerical burdens.
4. The information should reveal pupil health needs. It should point the way to individual and group guidance, and to individual and group participation.

The cumulative record, as developed in Hastings, provides for a six-year record beginning with the junior high school.

A PICTURE OF INDIVIDUAL PUPIL

The recorded data on the face of the card present a picture of the individual pupil. This picture includes information on his organic status—his strengths and weaknesses; his nutritional status; his aptitudes and achievements; his interests, vocational and recreational; his activities, in school and out of school; his strains, fears, worries, and conflicts; his behavior patterns that influence health; his relationships with adults and fellow-pupils. The data show certain factors which influence his health, such as home environment, family relationships, and home opportunities and limitations.

The sources of these data are the health examination, teacher observation, physical fitness tests, home visits, study of absences, objective tests, an analysis of the pupil's twenty-four-hour day, a home inventory, socioeconomic tests, classroom projects, and individual conferences with the pupil.

It is apparent that a great deal of emphasis has been placed upon determining individual health needs. Much of the health work in the school is concerned with the individual. For instance, when we get the data assembled, we find such pictures as this:

Mary, who is thirteen years of age, shows no increase in weight for more than a year. She has asthma, diseased tonsils, and a rapid heart. She was absent five days during a six-weeks' period. She takes private tap-dancing lessons, participates every day in tap-dancing and roller-skating, in addition to the regular physical education period, and attends movies twice a week. She has, on an average, eight hours of sleep. She is an active member of a Scout group. The teachers say she is good in her work but shows signs of fatigue.

This is definitely a case for individual guidance.

A PICTURE OF GROUP NEEDS

It is largely through a study of the individual needs, however, that we find our group needs. For instance, an analysis of the individual data of one group shows such interesting facts as the following:

The size of family ranges from 4 to 15.
The homes vary in size from 3 rooms to 15 rooms.
The families belong largely to the industrial and laboring groups.
No pupil has a room of his own.
No pupil has a family physician.
100 percent have dental caries.
100 percent have inadequate diet.
82 percent of the fathers and mothers work.

22 percent of the pupils are in families on relief.

15 percent do not have bathroom facilities.

6 percent do not have electric lights.

20 percent are ashamed of parents and relatives.

50 percent have American-born parents.

80 percent attend movies once a week.

20 percent attend movies twice or more a week.

70 percent belong to no clubs or groups in school or out of school.

10 percent take music or dancing lessons.

100 percent have radios in the home.

80 percent worry about home work, school work, and when they "make mistakes or fail."

In another school, located in a community of high socioeconomic status, we used a slightly different technique in finding group needs. We attempted to get a picture of the "average child." In this group the "average" pupil is an American. He comes from a small-family home. The father is a professional man, and both parents are college graduates. The "average child" has a family physician, and regular dental attention. He belongs to clubs, and takes private dancing and music lessons. He has his own room and his own spending money. He has many interests and friends. He is brought to school in a car. He is excitable and overstimulated and does not have a regular bed time. He buys candy or ice cream every day. His diet is inadequate. He makes frequent visits to the nurse.

STUDYING COMMUNITY FACTORS

In determining the health needs of the individual and of the group, necessarily the community itself must be considered. What are the factors in the community which influence pupil health? What public health and sanitary measures are enforced or neglected or violated? What health problems are created by the population groups in the community? Are there industries within the community which create health problems? Are housing regulations enforced? Are there traffic hazards, fire hazards? What provision is made for recreation? To what degree do school pupils patronize commercialized recreational institutions? What health agencies are operating in the community? What health facilities are available? To what extent are facilities used? What do the vital statistics and the morbidity rates indicate? These and many other questions furnish a background for understanding health needs of school pupils and furnish a wealth of material for practical pupil investigation.

So much for the *methods* which have proved effective in finding health needs. It appears that much of the thinking and planning in finding health needs is carried on by adults. This is in part true and it is necessary. If we wish to have the pupil and pupil groups "carry on," provision for carrying on must be made by adults. Furthermore, we cannot plan for pupil growth and pupil understanding of health practices until we have teacher growth and teacher appreciation of ways of living.

However, the pupils also share in finding pupil needs. Preparation for the health examination is made in the classroom. The pupil wants to "find out how good I am." This causes the health examination to be a real educational experience. The pupil is guided in understanding himself. For instance, there may be a very close relationship between his physical fitness index and the findings in his health examination. He may want to be a long-distance runner, yet really should be a sprinter.

Naturally the next question is: What are we going to do about health needs of the individual and the group? This is determined largely by our point of view on health. Health is in part a matter of individual conduct, of personal control. It is a matter of what the individual, with his potentialities and his limitations, does, or the way he lives in his environment. We are con-

cerned with personal efficiency and social efficiency; with the *I* in relation to the *we*. We are concerned with change; with growth. And we are concerned with the direction of this change. We want the individual to assume more and more responsibility, to be more self-directive in matters relating to health. We want change, but in the right direction—change which is socially desirable.

MOTIVATING CONDUCT

This means we are concerned with standards which are high on the scale of social values. The problem is to capture the interest of the pupil and to guide this interest in the direction of socially desirable standards of behavior. It is a matter of incentives. It is a matter of participation. The individual is going to do what he *wants* to do. He is going to do those things that have value for him, that give him the greatest satisfaction. He has certain fundamental wants, urges, and drives. He has his urge for self! for self-preservation. Who is not interested in self, in the *I*? He wants the satisfaction which comes from achieving. He wants success; fulfillment. He wants recognition, attention, and approval. The *I* wants to become an accepted one of the *we*. He wants security. These wants and drives become powerful forces in determining behavior. They need guidance. They need to be satisfied through activity—through participation in activities that are satisfying. The pupil must have many opportunities to solve his own problems of living. Problem-solving is the method.

"FED UP" ON HEALTH

This is the point of view which has influenced the development of the following pupil activities. In one sixth grade, the teacher and the pupils were "fed up" on health. These pupils had had five or six years of health instruction; many "do's" and many more "don'ts"; many promises and threats. "Do this and you will be strong and healthy." "Don't do this and you will be strong and healthy." Our problem was: How can we get the children to wish to do the desirable, healthful thing? We wanted to provide a new approach to an old problem. We wanted to use the interests and fundamental urges of children as incentives. We wanted to say very little about health, yet achieve everyday healthful living. We wanted to create certain desirable concepts of change, of growth and development. So we asked the following questions, giving a week for the pupils to write their lists for each group of questions:

1. Can you remember when you first started to school? Can you remember anything about yourself as you were then—what you did? In what ways do you think you are different now?
2. What do you want more than anything else? What do you want to do more than anything? Is there any person whom you want to be like?
3. What can I do now that will help me achieve number 2?

Space does not permit giving their answers, which were all tabulated. As a result of this activity the pupils agreed that change had taken place and would continue to take place; that changes "didn't just happen over night," but that they took place gradually. The pupils were divided in their opinions about controlling change or "doing something about it." Some had the idea that "you can't do anything but take it."

This activity resulted in a number of other projects. The third question led to their exploring many fields. For instance, some of the girls wanted to be "the best nurse." Several boys wanted to be the "champion swimmer." Thereupon, we tried to find out what is involved in becoming the best nurse, or the champion swimmer. By the time a number of fields had been explored,

many health practices were listed as essentials for living.

A curious change in attitude took place. Health ceased to exist as something to be achieved in itself. Gone was the do-this-for-health attitude. The pupils were interested in everyday efficient living. Since there was doubt in their minds about controlling change, a number of experiments with plants were carried on in the science class. Plants were subjected to many different conditions with reference to sun, soil, and water. The pupils found that growth does take place under favorable conditions and that there are certain essentials for physical growth.

HELPING PUPIL HELP HIMSELF

An important principle of mental hygiene is: A healthy personality is an integrated personality. It is essential that an individual have a definite task, a plan, and freedom to carry out the plan. We also frequently hear the admonition, "Face reality." We wanted to provide a means by which pupils would make a plan and carry it out; a plan that would provide opportunities for freedom, for self-direction, for pupil responsibility; a plan by which the individual could face without embarrassment any limitation or weakness or irremediable defect and find a way of using his strengths. We wanted to put challenge into living.

The cumulative interpretative record to which reference has been made is an effort to help the pupil help himself. The face of the card reveals certain strengths and weaknesses. This is filed in the pupil's individual folder with the teachers' observations and other data. All of this information provides the basis for a counselor-pupil-parent conference. During the conference, the pupil himself fills in the reverse side of the cumulative record. This is in answer to the question: What can I do to make myself better? Space is provided for:

1. Health habits. What specific health practices do I need to work on?

2. Corrections. What is interfering with my chances of success and happiness? What weaknesses do I have? What can I do this week, this month, or this year to "clear the way," "to give me a chance"?

3. In-school activities; out-of-school activities; home activities. In what activities can I contribute something? In what activities do I need to participate? In what activities can I work for improvement? What responsibility can I assume? What skills can I develop?

4. Development of personality adjustment. How can I have more friends? How can I get along better with other people? Have I developed patterns of behavior that interfere with social efficiency?

5. Participation in community protective measures. Do I observe public health regulations such as quarantine, immunization, garbage disposal, care of food and milk, control of communicable disease? What can I do to make myself a better citizen?

PUPIL CANNOT CARRY LOAD ALONE

This is only a part of the story. If a problem exists, there are always causes. We not only have to remedy the damage done, but we also have to remove the causes as far as possible. While emphasis is placed upon pupil responsibility, the pupil cannot carry the load alone. He cannot plan for certain health practices and carry them out if no provision is made for them at home and at school, in time, facilities, and awareness on the part of others of what he is trying to do. He cannot carry them out if there are not certain facilities in the community.

The parents and teachers must know something of the plan so that they may assume their legitimate responsibilities and contributions. The school administrator must know something of the pupils' health needs so that he may provide for facilities and time, and if necessary, provide for opportunities supplementing those found in the home and in the community.

In the counselor-parent-pupil conference where the pupil makes his plan, the school and the home are represented. The counselor and parents must assume

their share of the responsibility. They, too, must make a plan so that the pupil has a chance to carry out his plan.

For instance, the following plan was made for Mary, who was referred to above:

Provision was made through coöperative efforts of the home and school for Mary to ride to school in the school bus. Rest periods were arranged for her during study period and gymnasium period. Her schedule was changed so that one of the periods preceded the lunch period. Arrangements were made for treatments for asthma. Plans were made by which she could go to a summer camp.

Another illustration of this joint planning is the case of Rose:

Rose is a bright eleven-year-old girl, taller and more developed than other members of her class. She is nervous and irritable, and cries easily and frequently. The mother complained about her low grades. It was found from the card record that she was taking out-of-school dancing and piano lessons, was active in girl scouts and church activities, belonged to a club and a "gang," and had several radio programs that she "just had to listen to." Her mother wanted her to do all of these things, and exercised pressure to satisfy her own ambition for attention from the boys. The mother insisted on an early bed time. The child said in a counselor-nurse conference that there was no time for study and that she was too tired. The counselor and mother and child arranged a schedule for work, giving up some of the outside activities. The home-room teacher coöperated by giving daily encouragement to the child and by helping her to weigh values.

Other plans in meeting pupil needs have involved the pupil, the school, the home, the local clinics, county agencies, and even state agencies. They have involved changing the attitude of parents, which often requires several years.

GROUP NEEDS

Frequently the same problem occurs in so many individual cases that it becomes a group problem and requires coöperative planning. For instance, the problem of recreation was approached in this way. The individual records and a community survey* revealed that over half of the school population was living in a congested industrial district, with a population largely foreign, and with inadequate housing. The pupils did not want to go home after school hours and there were only a few places for them to go. These were the library and the drug store, and later in the evening, the dance hall. This became a school-community problem.

The Community Service Council has a full time director of recreation. A Boys' Center has been organized and a summer program developed. The school has adjusted its program and facilities to meet the demands of the community. The recreational activities in school and in community are very definitely coördinated. The police department has been brought into the picture in a unique way. The officer refers any offenders to school authorities who are serving on the various divisions of the Council, or to the Recreation Division. The referral to these authorities is not for disciplinary purposes, but rather for guidance and coöperation in giving the offender a chance.

One more illustration. In an effort to plan for out-of-door recreation for pupils living in the congested district and to help them make their surroundings more attractive, a garden project was started in the guidance classes.** This is now a community institution. It involves many local and county agencies and clubs.

PROBLEMS DUE TO CONFLICTS

The individual record also reveals a host of baffling problems which have to do with group living and which are the results of a wide range of socioeconomic conditions, of home relationships, and of school relationships. These problems have to do with conflicts created within

*Hopkins, John L. A Program for the Development of More Adequate Secondary Education in a Suburban Area. New York University, New York, N.Y., 1936.

**Davey, Mildred, "Children's Gardens as a Community Project." *Recreation,* March 1938, p. 710.

the individual, which result in "bad" behavior.

There are taboos and prejudices against foreign nationalities because their ways are not "American" ways. Some pupils have generous allowances; others, according to tradition, have to give the money they have earned to their parents. Sometimes because of a language handicap a child is placed in a special or low group at school, and this is considered a stigma. Some children may entertain friends in their homes; others have no place in which to entertain, so they find a substitute which subjects them to criticism. There are the conflicts between tradition at home and teaching at school. There are conflicts in customs, in moral standards, and in standards of living. There are the conflicts and frustrations resulting from long-continued relief.

There are the conflicts and problems caused by fear: fear of people; fear due to misunderstanding; fear of medical treatment, of the doctor, nurse, and dentist; fear of instruments. The school nurse had tried for two years to get an x-ray of the lungs for a boy in the sixth grade. Finally the nurse, mother, and boy arrived at the clinic. The mother saw the x-ray machine, and mother and son fled.

The problem, then, is one of "Americanizing" the children and parents of foreign nationality and in a sense "foreignizing" American children and parents so that there is a greater degree of toleration, understanding, and appreciation of the problems of others.

The idea is to find not only what are the causes of health problems, but also who can do what in meeting the problems, in removing the causes, and in preventing other problems. This means that the individual and joint responsibility of the school personnel must be determined and the community agencies which are available must be ascertained.

The nurse participates in the health examination and in the individual conference with the pupil. She learns the home conditions and attitudes of the parents and interprets them to the school. She interprets to the parent and to the school the child's health problems, the physician's recommendations, and the services which are available in community agencies. She helps the teacher and guides her in her health observations of the children, in interpreting pupil behavior, and in working out solutions to health problems.

ENTIRE COMMUNITY COÖPERATES

The pupil and even the school obviously cannot meet health needs alone. The coöperative efforts of the entire community are necessary. The most effective method is problem-solving.

Another activity which finally involved the school, the home, the church, and certain community facilities started with a nutrition study. In a sixth grade we started out with the problem, "What do I do with my 24 hours a day?" During a combined art and arithmetic period each pupil made a circle which he divided into sections representing the 24 hours of the day. With colored crayon, he indicated what he usually does during a 24-hour period. Then, according to the pie chart, the number of foot-pounds of work which he does during a usual day was figured. Logically, if we want to grow, we must provide for growth and repair.

This activity developed into a nutrition project which eventually involved the diets and rest and sleep periods for the entire family. We found answers to such questions as: How much work do I do during the 24-hour day? How much food do I need for repair and for growth? How much rest and sleep do I need? What do I need in the way of food? What foods supply these needs? How much should it cost? How much and what kinds of food do the different members of my family need? How much do they cost?

In all of the activities, whether individual or group, self-direction, responsibility, and consideration for others have been stressed. However, in the lower grades, it is sometimes necessary to plan deliberately for such opportunities. The teachers in various grades had a group discussion about the meaning of living together in the group and the responsibility of each member of the group to the group.

The first change in procedure was substituting pupil participation for the routinized teacher inspection of pupils. Teachers and pupils decided that the children themselves could assume responsibility in checking themselves not only in the morning but at any time during the day. Through various means mirrors were secured for each room and placed in a good light, conveniently for the pupils. In the primary grades, strip sentences, serving as guides, were placed by the mirror. Some of these sentences were: Am I ready for school? Am I ready to be with my classmates? Can I keep the books and papers clean for my own use? Can I keep books and papers clean for the use of others? Are my wraps hanging on my hook? Am I dressed according to the weather? Did I clean the washbowl when I used it? Did I leave the toilet room clean and sanitary?

Some of the upper grades are calling this activity *taking inventory*. In the upper grades, the children felt that some committees were necessary in order to carry on the work. Some of the committees were: medical and sanitary committee, housekeeping committee, cloakroom committee, bulletin board committee, lighting committee, ventilating committee, library table committee, weather chart committee, cafeteria committee, and safety committee. They were carefully organized and their functions clearly defined.

A different procedure in meeting the same problem was followed in another school. All grades from the kindergarten through the sixth grade had group discussion and worked out *standards for group living*. All of these standards were submitted to a committee of pupils which in turn prepared *our school standards for group living*. Three pupils presented these in a parent-teacher meeting.

STUDYING COMMUNITY PROBLEMS

The pupils frequently can be of value in considering community problems. The question came up: If prevention and control of communicable disease mean anything, why are so many persons ill with communicable disease? The first approach was to list the causes of the spread of communicable disease. This was submitted to the school physician for correction and suggestion. Then each cause was analyzed in terms of what can be done about removing it: Who can do what? What can the pupil himself do? What can the school do? What can the community do?

The same plan was used in studying the safety situation in Peekskill. Due to an enormous number of motor-car accidents, the superintendent asked that safety receive major consideration. In one school a committee of pupils collected data covering a period of three years from the office of the chief of police, the local health officer, and the county health department. These accidents were indicated on a map of Peekskill by colored pins, using a different color for each year. From this it was evident that accidents were on the increase and that they clustered around certain areas. Another committee investigated these hazardous points, took notes during their investigation, and also took kodak pictures of these points from four directions. The class studied these findings and prepared recommendations for the superintendent. Another committee of pupils with one of the mothers as chaperone studied the behavior of people at a busy street crossing in the business part of town. Another com-

mittee studied pupil behavior around the school building. From these data the pupils prepared a safety code.

One of the fundamental drives is the hunger for security. Promises do not give this security. It depends upon the individual—how he meets his problems of living, and the confidence with which he faces them. This confidence can only come from participation in meeting problems; from experiencing the thrill which comes from meeting a problem, planning a solution, and seeing it through successfully. The pupil has the right to have the thrill of success.

NOTE: The work described in Hastings-on-Hudson is under the guidance of Mildred A. Davey, guidance counselor, Junior High School.

Programs outlined here are under the direction of Catherine Moore and Esther Travis, teachers, Hastings-on-Hudson; Mercedes Rossi and Louise Finch, teachers, Peekskill; J. C. Weeks, principal, North Salem; and Anne Shea, principal, Park Street School, Peekskill.

We Change from Old Ways to New

BY ELIZABETH SAMS, R.N.

How can the nurse use her professional magazines? A Kentucky nurse tells how her program was revolutionized by two articles

"I AM SCHEDULED for the Crossroad schools tomorrow to weigh and measure the children. Another backbreaking day of lifting scales in and out of the car. But I am glad my program is planned in advance. Oh! Here is PUBLIC HEALTH NURSING—the school health number. I think I shall glance through this for some new ideas."

Such was my soliloquy in the office of the county health department in remote rural Kentucky one warm afternoon last September. That glance through the magazine turned into an hour or more of reading and became the turning point for the reorganization of our approach to the school health work in the county.

Every public health nurse knows that her work activities must be planned well in advance if she is to carry out a worthwhile program and accomplish satisfactory results. However, it took two articles in the September 1937 issue of PUBLIC HEALTH NURSING to bring to my attention the need for checking and evaluating one's program of activities in terms of the newer knowledge and more recently accepted educational procedures.

After rereading very carefully two articles in this school health number—"New Ways for Old in Rural Health," by Reba F. Harris, and "Present Trends in Health Education," by Dr. C. E. Turner—we worked out our program for the school-age child step by step. By means of the analysis scale in Miss Harris' article we evaluated all our work in the schools. "New ways for old" kept ringing in my ears. Finally our program was reorganized according to this analysis. The next question which confronted us was: How can we get these changes over to a rural population?

TEACHING THE COMMUNITY

Since the school fair is quite an important event in our county, it occurred to us that this would present an opportunity for bringing to the attention of the community the idea of changing from the old to the new. The fair opened in October with 4000 teachers, parents, and children in attendance. The health booth was one of the most important attractions. It was gaily decorated with multicolored health posters,

many of which were made by the pupils. The displays were arranged so as to set forth the principles of the new ways. For example, one display contained a large sign, *The Model School Lunch.* Under this sign was a lunch box containing sandwiches neatly wrapped in oil paper, an apple, a bottle of milk, and a bottle of soup (to be warmed at school). Diet cards for the school child and suggested lists of school lunch menus were convenient for distribution.

Another display was entitled, *Newer Methods in Weight Evaluation.* Under this sign was a tape measure tacked on the wall ready for taking measurements of height. Also on the wall was a large-size weight graph for an imaginary pupil. A set of scales stood ready for weighing, and on the free distribution table nearby were copies of directions to teachers for the newer methods and uses of weighing in the schools.

Since school and home are so closely related in health teaching, another display was entitled, *Sanitation Starts at Home.* Here we had a model wash-bench as it should be in the rural home. On it was a washbasin, with soap and scrub-brush in a dish. A mirror hung nearby. A towel, washcloth, and tooth-brush for each member of the family, with a name over each nail, were hung on either side of the wash-bench.

The comments heard from teachers, children, and parents throughout the fair and for many days thereafter were definite indications of their interest.

NEW WAYS FOR OLD

Following the county school fair, every opportunity was taken to convey to the county superintendent of schools and the teachers the idea of keeping the health work done by the county health department in harmony with the newer methods of teaching and the more recent medical knowledge. By the end of the school year in many of the conservative rural schools and remote rural communities—and I might add in the nurse herself—there were evidences of "the new." Teachers and parents took a greater interest in vision and in classroom lighting, as shown by an increased number of eye corrections and changes in lighting facilities and their use.

Such things as a balanced diet, the value of milk and codliver oil, increased rest, proper recreation, and communicable disease control, were discussed by children and teacher—not by the nurse in old-fashioned health talks. Children in the primary grades who came long distances by bus to the consolidated schools planned for a rest period after lunch. Small rugs and newspapers were brought by the children that they might lie down on the floor, carefully protected from drafts, for about one-half hour.

And now there is no more carrying of heavy scales or checking of underweights and overweights by the nurse (thanks to that September issue). A local hardware store gave an extremely low rate for scales if a quantity was purchased throughout the county. Two of the largest schools purchased these scales. Others followed suit. In these schools, teachers are now carrying out the newer approach to weighing and measuring. They have a regular weighing day, and each child is taught to weigh himself and keep his weight record.

Many of the teachers are discussing with children ways and means of gaining weight. We attempt to keep before the teachers, however, that if a child shows a loss of weight over a period of three months, he should be referred to his physician for examination.

So in this rural area, the public health nurse in a county health department, after a few hours with her professional magazine, became imbued with the idea of evaluating her own work in the rural schools, and was able to pass this spirit on to the teachers.

The Nurse in the School Community

By HELEN C. MANZER, R.N., Ph.D.

The nurse is able to carry on an effective health program in the school only when she develops a close working relationship with other members of the school staff

THE NURSE whose professional activities consist of caring for the health needs of the pupils and teachers in a school system is an active participant in a complex society. Like any society, the school is an aggregation of human beings, each of whom is performing a specialized task which has for its final outcome the benefit of all. It is important for every individual who is professionally connected with the school—and especially for the nurse—to realize that specialization of function and active social participation go hand in hand. One of the risks run by all specialists, one of the "occupational hazards" of specialization is the tendency for each to work so intensively at his particular specialization, to concentrate so faithfully on doing an excellent piece of work, that he loses contact with the interconnections and meaning of the society of which he is a part.

This absorption in one's task to the exclusion of outside interests is actually encouraged by society itself. There is something noble and appealing about the scientist who foregoes contact with the common crowd to devote himself to his microscope or telescope in laboratory or observatory. Such adages as "the cobbler should stick to his last" and "tend to your own knitting" have been a part of the upbringing of all of us and have had their permanent effect in the establishing of social attitudes. It is true that the cobbler should stick to his last and that we should tend to our own knitting. But these truths, derived as they were from social conditions that prevailed in the time of our great-grandparents, have not prevented the development of great boot and shoe factories and enormous textile industries. That is to say, far from there being any contradiction between specialization and social participation, these two functions are mutually interdependent.

The old, pedantic distinction between "pure" and "applied" science has almost completely broken down. Pure research has become the foundation of social applications, and the requirements of society have become the most fruitful starting points for pure research. No line can be drawn, for example, between the value of laboratory studies in the field of the vitamins and the effect of the results of these studies upon our eating and buying habits. The history of science is full of instances of laboratory curiosities and trivialities which later have become vitally significant for some phase of our social living.

FROM LABORATORY TO LIFE

How does all this affect the school nurse? Where does she stand on the path between pure and applied science? The school nurse, like each of the other specialists in the school system—administrator, classroom teacher, physical educator, visiting teacher, physician, and psychologist—makes some phase of scientific knowledge socially available. In other words, the school nurse bridges the gap between the vast body of knowledge about health which has been developed in the laboratories and the

specific health problem of the individual boy or girl. But as the steam-fitter cannot put all the pipes into a building without taking into account the work of the architect, the contractor, the masons, and the carpenters, so the school nurse cannot introduce and maintain an effective health program in a school without coöperating intimately with the other professionally trained workers.

It is unfortunate but true that a rather common criticism directed at certain of our school nurses relates to their tendency to concentrate so closely upon their particular job that they lose contact with the other professional persons in the school system. One classroom teacher in a school of only moderate size, upon being asked casually about the health work, said that they had the services of a nurse but she did not have much direct contact with the nurse herself. A principal, when asked if the school nurse ever attended his staff meetings, said "No," and then added, laughingly, "but she might if any of them should take an ill turn."

How may we account for the tendency on the part of these nurses to carry on their work almost completely isolated from the other members of the staff? How are we to explain their inclination to reduce their contacts with teachers and principal to those that are absolutely necessary? It is clear that some of the reasons which account for this situation lie mainly with the school nurse, while others are inherent in the school system.

THE NURSE ISOLATES HERSELF

Some nurses feel strange or out of place in the school situation. They consider that a school is an institution made up of classroom teachers and educational administrators, and that because the nurse is not a teacher she is an ornament or an oddity. There are few emotions more painful than the feeling that one is unwelcome or merely tolerated. It is no wonder, then, that a nurse who has this attitude toward her school should withdraw from those contacts which cause her pain. Alone, within the protection of her little "infirmary" or "hospital," she convinces herself that she can do a good job without becoming involved in the complex life of the school. Since an attitude within an individual readily builds up its social counterpart, the other members of the school community come to regard the nurse in terms of a service to be rendered only in emergencies, not as a member of the regular school group.

Working in an atmosphere that is saturated with teaching—with teaching techniques and procedures—some school nurses come to feel that the activities of the nurse are on a lower plane than that of the classroom teachers. Within the thinking of these nurses there may remain fragments of the outworn philosophy which divided human affairs into two compartments, the mental and the physical, and implied in this division that the mental was superior to the physical.

Among nurses as among all other human beings there are many individuals who are extremely dependent for their professional morale and self-confidence upon intimate and constant association with persons who are like themselves and who are engaged in activities that are the same as theirs. Conversely, these individuals feel ill at ease and become self-conscious and diffident if they are required to carry on their duties within a group that is different from themselves. Under the latter conditions these persons feel conspicuous. They crave the protection of a group of their own kind and gradually develop a tendency to belittle themselves and their accomplishments.

Partly as a result of the assumption that those who teach must know a lot and partly as a consequence of the emphasis that is placed in some educational circles upon the possession of

higher academic degrees, many nurses feel intellectually and educationally inferior to the classroom teachers, supervisors, and administrative officers of their school system. It is only natural that those nurses who have this feeling of inferiority should shy away from contacts with persons whose presence makes the nurse aware of what she regards as a limitation within herself.

TIMIDITY TOWARD AUTHORITY

Certain nurses, particularly those who have been on the staffs of the more strictly regimented hospitals before entering the field of public health nursing, have deeply rooted habits of timidity and submissiveness toward all persons who hold positions of authority over them. Developed first as a consequence of unfortunate relationships with their hospital superiors who have been overcritical, these attitudes of fear of superiors have become generalized. Such a generalized attitude makes these nurses feel fearful and timid toward all persons whom they regard as their superiors, irrespective of whether or not there have been any kind of unpleasant relationships.

These generalized attitudes are very common in all kinds of human contacts. It is not uncommon, for example, for a boy whose father has been oversevere and who has inflicted upon the boy drastic punishment for what the boy considered trivial offenses, to develop a hatred of relationships with any individual or group of persons that for him symbolize law, order, and authority, whether these be teachers, policemen, or society in general.

Undoubtedly there are many nurses who isolate themselves and their work from the rest of the school activities for the simple reason that they have not learned how to meet other adult men and women on a basis of ease and equality. It is not often realized that meeting people on terms and in ways that are socially successful is a highly intricate skill. This skill, like any other—such as speaking a foreign language, playing tennis, or dancing—is not something that comes naturally. Like these other skills, the techniques of social adjustment have to be learned. While it is true that some persons acquire the knack of carrying on successful social relationships more readily than do others, it is equally true that these methods and manners have to be learned by all of us.

Young adulthood is usually the time in which the skills of social adjustment are learned. But many persons whose early adult years have been spent in an oversheltered home or under the restrictions of excessively dominant parents, or whose home life has not included contact with a variety of persons outside the immediate family circle, grow into maturity without having learned these social skills. For a variety of reasons, many of us have grown to maturity without having acquired a fluent speaking knowledge of French or without having learned to swim. The lack of these skills is, to be sure, a less serious handicap than the lack of the skills which enable us to get along well with the men and women whom we meet casually or professionally. But the difference is merely a difference in degree. Implicit in both these situations is the fact that all these skills can be acquired through practice.

THE SCHOOL ISOLATES THE NURSE

In many school systems the nurse finds the classroom teachers banded together into small groups or cliques from which she is excluded. This tendency to form cliques seems to be present in nearly all human societies. One of the distinguishing characteristics of these small subgroups is the importance that is given to the difference between the "insiders" and the "outsiders." The insiders are proud of the fact that they are inside and they direct their efforts to keeping the outsiders out. The out-

siders, on the other hand, feel humiliated by the fact that they are outside and they in turn direct their efforts to trying to get in. The typical emotion of the insiders is pride or elation, while the characteristic feeling of the outsiders is envy or dejection. It is interesting to observe also that the insiders are usually very highly organized, while the outsiders are usually completely unorganized.

The extremes to which this tendency to form cliques will go are almost unbelievable. In a certain family, for example, in which there were three children, two of the children formed a clique of which they were the insiders, while the third child was the outsider. The bases upon which cliques form are as numerous as are human interests and attitudes. A community of intellectual interests is usually put forth as the basis upon which these small groups are formed, but one need not look far below the surface to see that the real foundation of these cliques is a similarity of emotion or attitude—a fact which is usually unrecognized by the members of the clique.

The nurse who finds herself excluded from cliques of school teachers should not feel too greatly disturbed. Let her realize that this tendency is for all practical purposes universal among human social groups. Perhaps this realization will help her to recall the existence of cliques among nurses in hospitals and on the staffs of public health organizations. A pleasant, courteous indifference to the presence of cliques among the teachers with whom the school nurse comes in contact is one kind of social adjustment that may prove effective.

NURSE STILL AN INNOVATION

Many school nurses are disturbed by the fact that they and their work are looked upon as something new. We should never lose sight of the extreme slowness with which human institutions and attitudes change. That which is old and familiar is accepted and welcomed; that which is new and strange is looked upon with suspicion and criticized. Everybody concedes the propriety of teaching reading, writing, and arithmetic in the schools; a smaller group admits the appropriateness of teaching art, music, and stenography in the schools; while a still more restricted group has come to regard the activities of the nurse as an integral part of the school program. To this day, even in some of our larger school systems, the school nurse is something of a pioneer. She should not be disturbed, therefore, if she is looked upon by the pupils, by the teachers, and even by certain school administrators as a novelty or a nuisance. While integrating the school health program in the performance of her daily tasks, the successful school nurse is never unmindful of the public-relations aspects of her work.

ISOLATION OF PHYSICAL SET-UP

In many of our school buildings, even in some of those that have been more recently erected, the health office is situated in a part of the buildings that is remote from the center of other school activities. Not infrequently it is necessary to go up two or three flights of stairs and through long corridors in order to get to the nurse's office. In certain buildings, the pupils and teachers who wish the services of the nurse must go to her office through a side door. The nurse herself in certain cases regularly uses a door which is different from that customarily used by the classroom teachers and the administrative officers. Because of these and similar factors of physical arrangement and location, the nurse and her work easily come to be regarded as remote and as different in kind from that of the other teachers.

Until very recently, the personnel of the typical school system consisted exclusively of classroom teachers and school administrators. For this reason,

members of boards of education and other persons responsible for the development of policies have come to have firmly established ideas regarding the persons and services that are necessary for the operation of a school system. It is inevitable, therefore, that the introduction of new kinds of persons with their strange functions will not meet with an immediate and wholehearted reception by all educational leaders and administrators.

As has already been indicated, the teachers of special subjects such as art and music have only recently been accepted as members in full standing of the school personnel. It is not surprising, therefore, that the school nurse in her turn should have to make a place for herself as these other specialists have done before her. In some schools the salary of the school nurse is in that part of the budget which is concerned with the maintenance of buildings and grounds; in other schools her salary is found listed among the members of the office and clerical staff. Such peculiarities and inconsistencies when they come to the attention of the nurse should not disturb her professional morale, but should rather merely remind her of the fact that the victory for the school nurse has not yet been fully won.

THE TEACHING POINT OF VIEW

Irrespective of the feeling of the individual school nurse or of the way in which she may be treated by other members of a given school system, the fact remains that the school nurse has become an integral and indispensable contributor to the effectiveness of any complete school program. The craving felt by certain school nurses for intimate association with other nurses engaged in the same kind of work and confronted with similar problems is entirely justified. Such a desire can of course be satisfied by attendance at meetings of public health nurses, but perhaps even more profitably by attendance at the meetings of organizations whose membership includes both teachers and nurses. At this kind of meeting the school nurse will have the opportunity to meet other nurses, to become personally acquainted with classroom teachers in other school systems, and to hear analyzed and discussed problems and procedures in the general field of education. She will come to understand the policies which are guiding teachers and to appreciate the meaning of the terms in which they are thinking. In this way she will gradually begin to speak the same language as that spoken by her fellow teachers. The development of a body of educational thinking common to both classroom teachers and school nurses will be an effective aid in the growth of friendly professional relations and a spirit of unified morale between these two groups.

It is impossible to overemphasize the fact that the school nurse is a teacher in the most thoroughgoing sense of the word. She is a teacher not only of the pupils who come to her for health inspection and other recognized services. She is a teacher also—in the field of health and general physical welfare—of the classroom teachers, supervisors, administrators, and office employees within the school system. The adequate discharge of her responsibility as teacher requires that the nurse expand her understanding of the teaching function. She must realize at all times that teaching is much more than standing before a class of pupils, book in hand, hearing recitations. Teaching is an activity of all professional workers, of all who possess a fund of specialized knowledge; it is essentially a relationship which the specialist develops and maintains with every person with whom he has any kind of social relationship.

It has been wisely said that "men should be taught as if you taught them not." This subtle, unconscious, and frequently unintentional kind of teaching is of the essence of that done by the

school nurse. Such an enlarged view of teaching will go far toward overcoming the embarrassment and feeling of inadequacy which hamper the efficiency of many school nurses. Although there have been nurses in certain of our school systems for many years, taking the country as a whole the services of the nurse in the school can still be regarded as an innovation. That is to say, the school nurse in many sections of the land is still a pioneer. For this reason she must possess the hardihood, the force of character, and the capacity for individual achievement which have characterized all successful pioneers.

Courtesy of "All the Children"

"Three little maids from school are we"

LEAD IN COLORED CHALKS

Lead poisoning in children which may be due to certain colored chalks is discussed in an article "Lead in Certain Coloured Chalks and the Danger to Children," by C. M. Jephcott in the *Canadian Public Health Journal,* August 1937.

A study of colored chalks produced by different manufacturers showed that all samples of yellow, orange, and green chalks analyzed contained relatively large amounts of lead chromate. Because children are especially susceptible to poisoning and there is danger of their nibbling crayons or inhaling the dust while cleaning blackboards, it is recommended that the use of yellow, orange, and green chalk be restricted or that non-toxic coloring materials be used which will not constitute a hazard.

The Children Build a Unit in Health

By IRENE SAWYER

Teachers frequently ask, "How shall I build a unit in health?" An eighth-grade teacher tells how a unit was developed around the children's interests and needs

OUR EIGHTH GRADE during the past year developed an interesting and exceedingly profitable unit of work on *health*. The group consisted of 24 students—12 boys and 12 girls—representing widely varied home backgrounds and widely different abilities.

After checking over the past experiences and the needs of the group, we became interested in developing a unit of work with major emphasis upon conserving human resources, and minor emphasis upon recreating and playing, expressing and satisfying spiritual and aesthetic needs, and providing for education. All of these points of emphasis represent items within the scope of the curriculum which we have adopted for guidance in Santa Barbara County. We think that on the eighth-grade level the attack should be made from the aspect of the intelligent control of environment by the use of scientific techniques, and we hoped to give opportunities for participation in activities that would help the child to plan for further constructive development.

NURSE ASKED TO HELP

We are fortunate in having a very efficient and up-to-date health program for our schools. In planning for the inauguration of the unit the school nurse was asked to make arrangements for the county dentist to visit us early in the year. When the purpose of this request was explained, our school was placed first on the list of visits for the year. This is indicative of the splendid coöperation offered us by our county health department.

During the first week of school the county dentist brought his dental trailer to our school and talked to the class about the dental program. This service has been available for some time, and the students had participated in the program for several years. But this time their interest was not only upon the service to the individual.

The dentist's visit opened up a large field of investigation and led to work upon diet as well as care of the teeth. The students were particularly interested in the effect of scientific investigation upon dental theory and practice. They found three decidedly different theories upon such a simple subject as the correct method of brushing the teeth. This gave them experience in learning to evaluate the materials they were reading, according to criteria such as the date of publication and the source of information. Along this line they made an interesting collection of advertisements of toothpastes and mouthwashes, which they also evaluated.

The dental trailer itself offered opportunities to explore the subject of accurate record-keeping, sterilization of tools, and personal prophylactics. The fact that an up-to-date dental office could be wheeled into the school yard and by a simple connection with power lines be made ready for efficient service was in itself a vivid demonstration of intelligent control and utilization of physical environment by the use of scientific techniques.

In addition to the splendid impetus which the dental work gave the unit of work as a whole, the immediate results were exceptionally gratifying. The class took advantage of the opportunity for a check-up on their teeth. The participation in this phase of activity was one hundred percent, and a large number followed it up with visits to their own dentists, at the recommendation of the county dentist.

While we were still working upon problems suggested by the visit of the dental department, the annual audiometer tests were given throughout the school. Here was additional evidence of the increasing efficiency afforded by scientific techniques. We discussed the relative efficiency of the old types of hearing tests and the audiometer test, as well as the physiological aspects of hearing tests. Both the school nurse and the director of nurses in the health department met with the children during their discussion period, and helped to clarify their thinking.

WHAT DOES HEALTH DEPARTMENT DO?

The dental work and audiometer testing, coming at the beginning of their new study, awakened interest in the health department's program. The students wanted to know something of the set-up within the department, as well as the service rendered throughout the county. They asked the school nurse to talk to them about her other activities outside of the school, and to outline the program of the health department for the school year.

With the nurse's help we made out a tentative schedule of the school health program. The students wrote a letter to the county health officer asking him to talk to the class explaining the theory and practice of immunization. In the meantime they were reading all available material for information upon this subject. A week or so before the diphtheria immunizations were given in our school, the health officer came and gave the group a talk. They were a receptive audience, and showed by their questions that they were doing some very constructive thinking.

Since most of the students had been immunized at an earlier age, they asked the doctor if it would be possible for them to observe the procedure when the other children receive their immunization. When the time came we found several children who were willing to take the inoculation before the class. The caretaker for the school, who lives on the school grounds, brought his six-months-old son into the classroom, and the children watched attentively while his inoculation was given. The health officer had warned them that the baby might be startled and cry. When he only regarded the proceedings with wide-eyed amazement the children laughed delightedly. The students agreed that the baby had taken the inoculation very calmly and had been startled only by the sound of their laughter in the quiet room.

This method of dealing with the immunization and testing program proved to be so successful that we followed it throughout the year, and the class participated one hundred percent in the program. When the time came for the smallpox vaccinations, we discovered that many of the children had vaccinations which were several years old and that they were scheduled for revaccination. One boy came to me and asked me if I would go home with him and talk to his mother. He had been vaccinated for smallpox when a small boy in Italy and his mother felt that this was sufficient protection. He was very grateful when I accompanied him to his home, and he acted as interpreter. Between us we persuaded the mother to give permission, although from the amount of talking he did I am sure he must have touched up my statements a bit.

The talks by members of the health department in connection with the

health programs were of real value in creating a better understanding of community health service.

INVESTIGATING SCHOOL CONDITIONS

In addition to these projects the students engaged in a great many activities of their own. One group became interested in the subject of adequate lighting and proper room temperature. They investigated light meters, and the school purchased one for them. Then they made an accurate survey of lighting conditions throughout this school. They tested the light in each classroom at intervals during the day and in various parts of the room, keeping accurate records over a period of time, with weather conditions noted in the record.

At the same time they observed room temperatures and kept records of them. They consulted with the room teachers and the principal concerning conditions that were not ideal, and gave talks to the children in the other rooms. One room with a southern exposure presented a difficult lighting problem, and the students wrote for information on blinds and shutters and lighting equipment, apparently going into the subject more thoroughly than many builders do. We have individual electric heating systems in every room, and the children were consistent in keeping our room at the proper temperature. Needless to say, we had no problem of pupils who wanted to keep sweaters and jackets on in the room.

VEGETABLES FOR THE SCHOOL

Another activity was an outgrowth of the work on diet. The children made posters on the health values—particularly the vitamin content—of various foods and posted them in the cafeteria. The cafeteria reported a significant increase in the number of salads and vegetables sold, and a group of boys decided to make a vegetable garden to supply fresh vegetables to the cafeteria. They borrowed money from the student-body fund with which to buy fertilizer and seeds, giving their note for security. The spectacular storms during the winter ruined their first efforts, but they reseeded their crops. And while their plans were retarded, they sold enough to liquidate their debt and show a profit. You may be sure that the news accounts of storm damage to farm crops were of very real significance to these eighth-grade children.

The boys kept accurate accounts of their project. It provided excellent material for their arithmetic, for they made out notes, contracted and paid bills, and extended a charge account to the cafeteria for their produce.

Some members of the group tested seeds and experimented with fertilizers. Others in the class experimented with chemical gardens, working with both the sand-culture and water-culture methods. While these processes proved to be too complicated for the group, their interest was stimulated in another aspect of control of environment through the increasing use of scientific techniques, and we think the experiments were fully justified.

A DIFFERENCE OF OPINION

Another development resulted in the study of research techniques. One of the children wrote an article for our class newspaper in which she told of plans to use a rabbit or a guinea pig in our work on vitamins. The article was reprinted on the children's page of the local newspaper and resulted in a letter to us protesting against the use of animals for experimentation. The class discussed the viewpoint expressed, and the problem thus created provided a splendid opportunity for consideration of the proper way to deal with such problems. They finally decided to write a letter asking the person concerned to come to the school and talk to us further upon the subject. Then they wrote to the department of health and asked that

someone present the other side of the picture. We thought that this situation provided one of the most valuable learning experiences of the entire year, in that the students found themselves in a real life situation which called for tact and courtesy as well as an impartial consideration of both sides of the question.

Out of this experience grew a valuable study of research techniques and preventive medicine, and an interest in the outstanding people in the history of science and medicine.

Throughout the year we listened to the broadcasts sponsored by the American Medical Association on Wednesday mornings.* The information presented furnished a great deal of material for further discussion and investigation.

Although the work of the class as a whole on the health unit was terminated at spring vacation, several of the projects, including the garden, were carried on till the end of the year. When the time came for the Schick tests, the children asked if they could have someone talk to them about the test and its relation to the immunization given at the beginning of the year.

In addition to these and many other worthwhile experiences, the unit afforded stimulation for reading situations and ample opportunity for all types of written expression. The sequence in letter-writing alone was very valuable.

While the actual experiences and information gained were worth while in themselves, even more valuable were the attitudes that were developed toward the positive side of health education. For example, one over-age boy in the group, who presented a behavior problem, began taking the mid-morning milk and graham crackers provided for undernourished children by the parent-teacher association. He asked to be allowed to help clean up in the cafeteria twice a week during his noon-hour play period so that he could feel that he was making some repayment.

It is evident that the outstanding success of the work was made possible in a large measure by the fine coöperation of the county health department.

*See page 557.

Presented before the annual meeting of the California State Organization for Public Health Nursing, Santa Barbara, California, May 24, 1938.

Our Contributors this Month

This new column describing the authors who contribute to our pages will be published monthly hereafter.

Known to public health nurses everywhere through her *Handbook of Health Education* (reviewed March 1937) **Ruth E. Grout** combines a practical knowledge of school situations with special preparation in her field. She received her Certificate of Public Health from Yale University. Formerly a teacher in the New Haven High School (Conn.) she is now consultant in school health education, Cattaraugus County School Health Service, Olean, New York.

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Dr. H. D. Chope is director of public health in Newton, Massachusetts and instructor in public health administration in the Harvard School of Public Health. He was formerly director of the Bureau of Epidemiology in the Division of Health, Department of Public Welfare, St. Louis, Mo., and assistant director of the California State Department of Public Health. Medical journals to which he has contributed include the *Journal of Industrial Hygiene and Toxicology, The Journal of the American Medical Association,* and the *Journal of School Health.* He is a member of the Publications Committee of the National Organization for Public Health Nursing.

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The Pacific Coast has just claimed **Ethel Mealey,** who in August left her position as consultant in school health education in the Westchester Tuberculosis and Public Health Association, Westchester County, New York, to become director of health education in the Division of Maternal and Child Health of the State Board of Health in Oregon. Formerly on the staff of the American Child Health Association, Miss Mealey has contributed to educational and health publications, including *Hygeia, Review of Educational Research,* and *Fit to Teach,* the 1938 Yearbook of the National Education Association. She is active in the American Association for Health, Physical Education and Recreation, a Department of the National Education Association.

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An imaginative teacher whose career took her to Honolulu, T.H., for six years and to Alaska for four years before she settled in California to teach, **Irene Sawyer** is now on the teaching staff of the Montecito Union High School, Santa Barbara, California.

A well known heart specialist and writer of educational articles on medical subjects for lay readers, **Dr. Louis Faugeres Bishop, Jr.** is consulting cardiologist at the John T. Lather Memorial Hospital, Port Jefferson, L. I., and at Goshen Hospital, Goshen, N. Y., and associate visiting physician at Bellevue Hospital, New York City. He contributes frequently to *Hygeia* and gives radio broadcasts on medical subjects under the auspices of local health organizations.

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A supervisor of mental hygiene in the Visiting Nurse Association of Scranton and Lackawanna County (Pa.) and the mother of two children, **Katherine Brownell Oettinger** has contributed before to PUBLIC HEALTH NURSING, as well as to the *Survey, Hygeia, National Parent-Teacher, Mental Hygiene,* and other journals. She received her Bachelor of Arts degree from Smith College and her Master of Social Service degree from the Smith College School of Social Work. She has been a member of the staffs of the Charity Organization Society and the Associated Guidance Bureau of New York City, and the St. Paul Child Guidance Clinic (Minn.).

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Helen C. Manzer is associate professor of education at New York University, New York City, and is in charge of the public health nursing course there. She has the degree of Doctor of Philosophy from Columbia University, has had a broad experience in social, health, and educational work, and was formerly executive officer of the Committee on Health of the New York Principals' Association. She has contributed to *Hygeia* and the *Journal of Educational Sociology.* Dr. Manzer is a member of the Publications Committee of the National Organization for Public Health Nursing.

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A county nurse in rural Kentucky until recently, **Elizabeth Sams** keeps in touch with the latest information and trends in her field. She tells here how two articles in last year's school health number served as a guide in reshaping her entire school program. Miss Sams is now a student at the University of Kentucky.

The National Health Conference

"FIFTY MILLION Americans are in families receiving less than $1000 income a year; illness and death increase their toll as income goes down; medical care decreases sharply as need for it mounts."

With this and other statements defining the medical needs of the country, Josephine Roche opened the National Health Conference in Washington, D. C., where one hundred and fifty delegates met for three days, July 18-20, to discuss the nation's health problems.

The meeting was called at the suggestion of the President by the Interdepartmental Committee to Coördinate Health and Welfare Activities, of which Miss Roche is chairman.

Although the Conference was kept numerically small in order to permit free discussion, it included representatives of all groups vitally concerned with health problems. Spokesmen of agriculture and organized labor and members of the employer group, the users of medical care, were present. Those who give medical service—physicians, nurses, hospital managers, social workers, and representatives of voluntary and official welfare and health organizations—were there. Present also were leaders of the nation's educational forces—its schools and universities; of public information media—the radio, press, and pictures. For the first time, an opportunity was afforded for free discussion between the users and the providers of health and medical service.

As a basis for discussion, members of the Technical Committee on Medical Care* appointed by the Interdepartmental Committee to study the health needs of the country presented in detail their findings and recommendations. Reduced to briefest terms these findings were:

1. Preventive health services for the nation as a whole are grossly inadequate.
2. Hospital and other institutional facilities are inadequate in many communities, especially in rural areas.
3. One third of the population, with or without income, is receiving inadequate or no medical service.
4. An even larger fraction of the population suffers from economic burdens created by illness.

To correct the situation the Committee makes five recommendations:

1. Expansion of general public health and maternity and child health services.
2. Expansion of hospital facilities.
3. Provision of medical care for the medically needy.
4. Development of a comprehensive program designed to increase and improve medical service for all the people. For plans to finance this, it is recommended that both tax assessments and contributions from potential beneficiaries of an insurance system be considered.
5. Provision of insurance against loss of wages during illness. The maximum annual cost to federal, state, and local government of carrying out the first three of these recommendations is estimated at about $850,000,000. Of this sum, $145,000,000 represents hospital costs for construction and support, while $705,000,000 is estimated as needed for additional health service and for medical care to medically needy groups.

THESE ARE large figures. Yet Charles W. Taussig, who is himself head of an industrial corporation, said of them: "I should like to emphasize that the expenditure of $850,000,000 for public health does not frighten business. Business bears a far greater financial burden now, due to our neglect of adequate health control, than its share of the tax burden will be under the proposed plan."

That a great need for increased health and medical service exists was not challenged by anyone at the confer-

*The Need for a National Health Program. Report of the Technical Committee on Medical Care, Washington, D. C., 1938. Reviewed in May 1938 issue, page 332.

ence. There was, however, a difference of opinion concerning what should be done about it and how.

Very impressive were the unanimity and force with which representatives of labor and agriculture demanded a health program administered and financed by government.

On the other hand, spokesmen for conservative medical opinion questioned the wisdom of long-term medical planning on the basis of the present economic situation. They thought that the primary need is for food, shelter, clothing, and jobs, so that more people may purchase their own medical service.

To this point of view proponents of the national health program responded that the day is past when private enterprise and private medical effort, no matter how generous, can meet health needs. Also, to quote Surgeon General Thomas Parran: "Our proven ability to prevent disease greatly exceeds our proven ability to control other causes of poverty."

That there are dangers in government interference with medicine was frankly admitted. But as Dr. Alice Hamilton—Consultant in the U. S. Department of Labor—pointed out, government is only *ourselves* organized, and it is surely susceptible to our influence. "If as a people we are going to deal with a great problem, then we have got to do it through our government," she said.

A modifying force will be found, according to several speakers, in the chronic individualism of the American people. It is believed that those who can afford to do so will usually prefer to secure medical care individually or through voluntary group plans. Dr. Parran's comment in this connection seems sound. "We should not continue to think in terms of separateness of public, private, and voluntary efforts or of the separateness of preventive or curative efforts to reduce death and disease. Each contributes to the health of the individual and the nation. . . . They frequently are not smoothly functioning parts. It is our job to make them mesh."

No action was taken by the conference, but it is expected that delegates will carry back to their various groups a report of this meeting and that discussion and constructive criticism of proposed plans will follow. Doubtless there will be a request to Congress at its next session for increased appropriations for health and medical service.

To public health nurses all of this is important in several ways. No group in recent years has been in a more strategic position to realize the need for increased preventive and curative medical facilities than have public health nurses. For lack of these facilities they have often stood helpless in the presence of sickness and suffering. They have seen disease in far advanced stages, that might have been cured or prevented if taken in time.

Moreover, any expansion of health service and medical care in homes will mean expansion also in the number of public health nurses and in their opportunities and responsibilities.

Finally, if expansion comes it will be the responsibility of nurses themselves and of their national and state organizations to safeguard the standards of the work and preparation of public health nurses. R.H.

Gleanings

This department is devoted to new ideas regarding improvised equipment, publicity programs, administrative problems, etc. Send us your contributions!

AN INFANT INCUBATOR

AN IMPROVED infant incubator for use in homes as well as in hospitals was described in *Health News*, bulletin of the New York State Department of Health, May 16, 1938: "The unit, illustrated here,* was developed for the Cattaraugus County Department of Health by a local manufacturer.

"In hospitals and most homes heat is supplied electrically by an insulated heating unit. The temperature is kept uniform by a thermostat at the back of the metal cabinet. In homes where no electricity is available, heat may be supplied by hot water bottles, heated stones, or flatirons placed in a space provided for this purpose below the infant's bed.

"The Allegany County American Legion has recently purchased seven of these units which are distributed throughout their county for loan without charge on request of local physicians.

"Both in Allegany and in Cattaraugus County, where a similar loan service has been provided by the health department for over a year, these incubators have been appreciated by parents as well as physicians."

It is suggested that service clubs, women's clubs, lodges, and other local organizations may be interested in securing a supply of these incubators and making them available on loan for the care of premature babies in homes in their community.

*A picture of the incubator appears on advertising page 5. It is available without the cart for use in homes. Prices and other information may be secured from the manufacturing company.

A SCHOOL CLEANS UP ITS "GYM"

THE ENVIRONMENT and use of equipment in the physical education department of a city high school presents acute problems of health and efficiency. The plan which was worked out in 1936 by the school health committee in South Bend, Indiana, to meet this situation may be applicable to other schools with similar problems.

One function of the faculty health committee* in each elementary and secondary school is to study the environmental conditions which are not conducive to healthful living and make recommendations for changes. The committee is composed of the principal, classroom teachers, physical education teachers, nurses, the custodian, and a member of the parent-teacher association.

A study of health conditions in one junior-senior high school revealed the fact that the condition of the shower rooms, suits, towels, and other equipment was highly undesirable from the standpoint of good health practice. Some

*For a description of the activities of these committees, see "The Nurse in the Modern School," by Lulu V. Cline, PUBLIC HEALTH NURSING, September 1936.

of the conditions found were as follows:

1. Locker-rooms were unsanitary and so crowded with lockers that they could not be kept clean, and the typical locker-room odor was ever present.
2. Unsanitary suits of all sorts, which could not be laundered easily, were found.
3. Towel service was poor; showers were being taken with soiled towels or none at all.
4. There was considerable loss of equipment due to poor locks and lockers. The replacement cost to parents for this loss was high.
5. There was a loss of efficiency in the department due to absence from class because of lost equipment.
6. Class morale was poor because of a lack of pride in personal appearance.

Our schools have a fee system by which textbooks are rented for $1 or $1.25 a semester. The committee recommended that physical education equipment be placed under this system and a fee charged. This recommendation was brought to the administrative body several times and finally the group was convinced that the plan was worth trying. It was worked out for the boys.

The cost of 500 suits, 500 socks, and 700 towels, and the wages of the laundress were to be taken from the fee money, which was 70 cents a semester for each student. A washing machine was purchased by the city schools and charged against the high school, the amount to be reimbursed from fees after a period of time. The installation of washer, drying lines, and other equipment was financed by the board of education.

The results have been gratifying. Our locker-room is mopped daily and is clean and sanitary at all times. The locker-room odor is gone. The suits are always clean and fresh. A suit or towel is used only once before laundering. Each boy takes a shower after class, using his own clean towel. Class morale is better. Pride in personal appearance carries over into street clothing.

The fees cover the cost of the equipment and the cost of operating the laundry. There has been no more loss of equipment. The department is operated with 100 percent efficiency. Every boy in class is dressed for physical education every day unless he has a medical excuse.

A practical "Gym" suit

There has been a 75 percent drop in cases of athlete's foot. In football last fall there was a 30 percent decrease in medical bills due to the decrease in the number of cases of this infection. We had, in fact, only one case.

This system worked so successfully that the girls asked for a similar plan. The cost of their suits was more than that of the boys' suits, so the fee was more—$1.25 a semester for two gymnasium periods a week. The suits were made of a heavy cotton fabric at a cost of $21 a dozen. They were designed by the school laundress, who is the mother of two children, and who had found the old suits most unsatisfactory.

The unique feature about this suit is its adaptability. The suits have no buttons and only one string loop. The adjustable belt line and the length of the blouse make the suit adjustable to all sizes. The suit looks well without ironing.

In addition to the suits, "gym" shoes were added this year and included in the physical education fee. Each pupil had his own shoes and at the end of the year they are given to him. Fortunately we have a tennis shoe factory in a near-by city. The salesman came over and fitted the boys and girls properly.

(Continued on page 559)

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

WITH THE STAFF

N.O.P.H.N. field activities have decreased, as usual, during the summer months because of vacations and the necessity for keeping an adequate staff in the office to take care of correspondence and visitors.

Ruth Houlton attended the National Health Conference at Washington, D. C., on July 18, 19, and 20. This meeting was called at the suggestion of the President by the Interdepartmental Committee to Coördinate Health and Welfare Activities for the purpose of discussing the nation's health problems. (See page 546.) While she was in Washington, Miss Houlton also attended a luncheon and an afternoon meeting of a subcommittee of the National Committee on Better Care for Mothers and Babies.

Virginia Jones visited the public health nursing course at the University of Kentucky, Lexington, Ky., August 1 and 2.

HONOR ROLL

Nursing agencies having all members of their staff enrolled in the N.O.P.H.N. for 1938 are eligible to receive an Honor Roll Certificate and to have the agency name appear on this list. Any agency may qualify, regardless of size—whether it has one nurse or many. There is still time to see that your agency appears on the N.O.P.H.N. Honor Roll for 1938.

Asterisks denote the number of years an agency has been on the Honor Roll, up to five years; the dagger indicates those agencies which have been Honor Roll members for five years or more.

ALABAMA

*Bullock County Health Department, Union Springs

COLORADO

*Margery Reed, Mayo Social Center and Day Nursery Association, Denver
*Jefferson County Public Health Nursing Service, Golden
*Routh County Public Health Nurses, Hayden
*Larimer County Schools, Loveland
*School Nurse, District No. 20, Pueblo
*Pueblo City Health Department, Pueblo

CONNECTICUT

†Visiting Nurse Association of Hartford, Hartford
*Stafford Chapter, American Red Cross Public Health Nursing Service, Stafford Springs

ILLINOIS

*Mercer County Public Health Nursing Association, Aledo
*Boone County Public Health Nursing Association, Belvidere
*Fulton County Public Health Nursing Association, Canton
*Metropolitan Life Insurance Nursing Service, Carbondale
*Carlinville Community Public Health Nursing Service, Carlinville
***Board of Education, Champaign
*Eastern Illinois State Teachers College Nursing Service, Charleston
*Charleston Public Schools, Charleston
†Chicago Tuberculosis Institute, Chicago
*Decatur Public Schools, Decatur
**Macon County Tuberculosis and Visiting Nurse Association, Decatur
*Lee County Sanitarium Board and Tuberculosis Association, Dixon
*City Health Department Nursing Service, Freeport
*Freeport Board of Education, Freeport
*Stephenson County School Nursing Service, Freeport
†Board of Education, Galesburg
*Monticello College Nursing Service, Godfrey
*Pope County Public Health Nursing Association, Golconda
*Metropolitan Life Insurance Nursing Service, Harrisburg
*Hinsdale Public School, Hinsdale
*City Health Department Nursing Service, Jacksonville
*Joliet High School and Junior College, Joliet
*Henry County Sanitarium Board and Tuberculosis Association, Kewanee
*Williamson County Public Health Nursing Association, Marion
*Western State Teachers College, Macomb
*Clark County Public Health Nursing Service, Marshall
*Mendota Public Schools, Mendota
*Public Health Nursing Service, Piatt County, Monticello

*Wabash County Public Health Nursing Association, Mt. Carmel
*LaSalle County Sanitarium Board and Tuberculosis Association, Ottawa
*Pekin High School, Pekin
*Pike County Public Health Nursing Association, Pittsfield
*Gallitan County Public Health Nursing Association, Ridgeway
*J. L. Clark Manufacturing Company, Rockford
*Rockford College Nursing Service, Rockford
***Rockford Visiting Nurse Association, Rockford
***Visiting Nurse Association, Rock Island
*Shelby County Sanitarium Board, Shelbyville
*Whiteside County Sanitarium Board and Tuberculosis Association, Sterling
*Cumberland County Public Health Nursing Association, Toledo
*DeKalb County Sanitarium Board and Tuberculosis Association, Waterman
*Iroquois County Public Health Nursing Association, Watseka
*Lake County Tuberculosis Association, Waukegan

INDIANA

***Noble County Health Department, Albion
****Elkhart County Tuberculosis Association, Goshen

IOWA

**Health Department, School Nurses, Dubuque

MAINE

**Brunswick Chapter, American Red Cross, Brunswick
*Hancock County Health Service, Ellsworth
†Lewiston-Auburn Chapter, American Red Cross, Lewiston

MICHIGAN

**The Greater Lansing Visiting Nurse Association, Lansing

MINNESOTA

*Chisholm Department of Health, Chisholm
*Rochester School Nursing Service, Rochester

MISSOURI

*State Department of Health, Division of Public Health Nursing, Jefferson City

NEBRASKA

*Visiting Nurse Association, Omaha

NEW JERSEY

†Perth Amboy Chapter, American Red Cross, Perth Amboy

NEW MEXICO

†Lea County Health Department, Lovington

NEW YORK

****Erie County Nursing Service, Buffalo
****American Red Cross Visiting Nurse Service, Geneva
**Metropolitan Life Insurance Nursing Service, Malone
*Metropolitan Life Insurance Nursing Service, Mechanicville
*Metropolitan Life Insurance Nursing Service, Tonawanda

NORTH CAROLINA

*Robeson County Department of Health, Lumberton

OKLAHOMA

*County Health Nurse, Creek County, Muskogee
*County Health Nurse, Okfuskee County, Muskogee
*County Health Nurse, Hughes County, Muskogee
*Coöperative Health District No. 1, Tahlequah

OREGON

*Polk County Health Association, Dallas
*Union County Health Unit, La Grande
*Crippled Children's Division, State Relief Committee, Portland

RHODE ISLAND

*Newport Hospital, School for Nurses, Newport

RETIREMENT PLANS

The Harmon Association for the Advancement of Nursing has prepared a mimeographed statement on its group retirement plans, including a description of the individual annuity available to nurses. The material, which concludes with questions and answers on points about which there may be inquiries, gives both the nurse and agency a clear picture of the plans, the benefits, and how to apply. Public health nursing associations interested in securing information on these plans may write to the Association, 140 Nassau Street, New York, N. Y., for a copy of the bulletin.

NEW BIBLIOGRAPHIES

Two recently revised N.O.P.H.N. bibliographies are of special value to nurses interested in maternal and child health. The old bibliography on this subject has been superseded by one on Maternity Care—which includes sections on mental hygiene, marriage and sex hygiene, the newborn, and maternal mortality—and one on the Infant and Preschool Child—which includes sections on nursery schools, sex education, child study references, diet and feeding, play and toys, and programs and services. Both are available at 10c each.

EDITED BY
ELLA E. McNEIL

STEP BY STEP IN SEX EDUCATION

By Edith Hale Swift, M.D. 207pp. The Macmillan Company, New York, 1938. $2.

This is a welcome addition to the rapidly increasing literature on sex education. Out of a rich experience with parents and children Dr. Swift, specialist in pediatrics and in social hygiene, makes practical applications of the theories so frequently put forth by parent educators.

The plan of the book is simple. A modern couple are conscious of the need to educate their boy and girl about sex. With many doubts but with a sensible courage they resolve to meet the situations arising from day to day. The "steps" are episodic conversations between the family members, in which correct information is given naturally by the parents, and questions and answers are freely exchanged. In the first "step" the boy is two years old; in the last he is twenty. The girl is two years younger. Frequently both children share in the episode.

Parts one and two are rather well handled. The situations developed are common to most households and are met by appropriate and unemotional parent responses. A valuable feature is the demonstration of how explanations made to the boy may be adapted to the girl, and vice versa. I should like to see simpler and longer introductions, suited to parents who know little theory and less technique.

Part three is not so well done. The area of sex education for adolescents is a large one—too large probably to be included in a book of this kind.

Unfortunately the book is not indexed in such a way that the parent can easily find techniques for meeting a certain situation. References to supplementary reading for both parent and child would be a helpful addition.

This book must be read to be appreciated. The situations are real, with emotionally tense possibilities met in such obviously simple and matter-of-fact ways that the reader feels he could easily have done it himself. Few other books give quite such encouragement to parents in a difficult field.

NEWELL W. EDSON
Erie, Pennsylvania

THE WISE CHOICE OF TOYS

By Ethel Kawin. 154 pp. University of Chicago Press, Chicago, second edition revised, 1938. $1.50.

One must realize in reading the title of this book how much is included in that word *wise*. Far from being a book to be glanced through hastily in order to get some help in buying a toy for a small niece or nephew, it throws light on the whole question of child development and the meaning and importance of play in the child's life. The *wise* choice of toys means an understanding of childhood; and the book is full of mental hygiene, as any book is which gives us a comprehension of wholesome personality growth.

The first edition, valuable as it was, has now become a second, revised edition. It comes to us in a new dress, a stiff cover, which will save it from becoming the dog-eared volume which a well read paper-covered book is bound to become. Its pictures are now illustrations of children in the act of playing rather than mere inanimate toys. It has an amplified Chapter IV on the classi-

fication of toys which includes a helpful discussion of play needs according to age-groups.

But best of all there is an additional chapter which should make the book especially valuable to the nurse, on toys for children with special needs—such as the convalescent child, and the child with a cardiac disability, with defective hearing or sight, and with spastic paralysis. Helping the mother of a handicapped child is so often our problem. And have we not many a time felt inadequate in the face of this problem insofar as it related to that fundamental need of childhood—play? This new chapter gives much practical help and also suggests the need for special study and research in this field, since little has been done as yet in studying the play problem of the handicapped child. What an opportunity for a nurse with the additional necessary qualifications to make such a study!

WINIFRED RAND, R.N.
Detroit, Michigan

PHYSIOLOGICAL HYGIENE

By Cleveland P. Hickman, Ph.D. 493 pp. Prentice-Hall, New York, 1937. $3.25.

During the past decade, books on hygiene for college students have tended to conform to a certain pattern. True, the emphasis has varied. But in general the pattern includes an introduction in which hygiene is defined and evaluated, followed by a presentation of the human body, system by system. The anatomy, the physiology, and the hygiene are discussed, with some attention to deviations from the normal.

Such is the general pattern of this book. As the author himself is a physiologist, perhaps more attention is given to function than in other volumes. There are parts which seem to have come from a text on biology, so much is the detail. To the writer, this seems good. College students demand a full description of the reasons why certain rules of hygiene are good before they will adopt them.

The physiological approach is so good that it is difficult to reconcile with the "rules" which appear at the end of each chapter—especially where they are unrelated to the previous discussion, or are annoyingly obvious precepts. For example, after a section on the sense organs is found a set of rules for care, among them: "Excessive use of tobacco is harmful to the eyes." This seems arbitrary and unscientific, unsupported as it is by any discussion. In the section on mental adjustments (the poorest part of the book) appear the following: "Form your main associates among your equals and superiors. Shun inferior people and situations." "Be well rounded." "Be efficient." "Avoid equivocation." The author is a better physiologist than psychologist.

All in all, the book is crammed full of information, with emphases on certain subjects which are not usually included or stressed in hygiene books. The appendix contains a concise section on first aid that seems useful, as well as tables on communicable disease and life expectancy. There are the usual drawings and illustrations, and the format is attractive.

JANE FOSTER, R.N.
Northampton, Massachusetts

THE NEED OF REDETERMINING SCHICK NEGATIVENESS IN SCHOOL CHILDREN

By A. B. Schwartz, M.D., and F. R. Janney, M.D. *The Journal of the American Medical Association*, May 21, 1938, p. 1743.

This article presents some of the findings of recent studies on immunization against diphtheria. Since the duration of immunity depends a great deal on natural restimulation of the immune response by exposure to diphtheria, the present low incidence of the disease makes it more important to test and to maintain the immunity of the school children. One study showed that one third of a group of preschool children who were Schick negative had lost their

immunity when retested five years later.

The recent increase in the incidence of diphtheria among supposedly Schick negative children warrants serious consideration of the present status of Schick immunity in the school population.

In order to maintain the low incidence of diphtheria it is recommended that whatever materials or method of immunization is used, one of the following measures be made routine:

1. Schick testing of all children entering school.

2. Administration of a routine dose of 1 c.c. of toxoid at the time of entering school. E.McN.

NEW STUDY ON HEIGHT-WEIGHT RATIOS

The Relation of Accelerated, Normal and Retarded Puberty to the Height and Weight of School Children

By Herman G. Richey. Monograph of The Society For Research in Child Development, Volume II, No. 1, Serial No. 8. 67 pp. National Research Council, Washington, D. C. 1937. 75c.

The way in which height-weight-age tables have been used for many years to find poor nutrition in school children and even as the only means of selecting undernourished children in school has made a strong impress upon school health service practice. In spite of biometric evidence and the warning of clinical pediatricians, the terms *underweight* and *overweight* for height and age are still used as diagnoses or interpreted as physical defects by many health workers.

The wish for a device as simple as the height-weight-age tables for selecting undernourished children will probably lead to further misinterpretation of these measurements. New analyses and studies of this complex problem will help to warn against such misuse of the measurements and to bring about improved practice.

This monograph gives new data on the influence of precocious or late onset of puberty upon the rate of increase in height and weight as well as the relation of weight to height. The boys and girls were each divided into three groups according to the age when they showed signs of maturation. It is evident that the age of maturity should not be neglected. To quote: "There are not only great differences in the heights and weights of the maturity groups, but also in the relation of weight to height. These latter differences are so large that it appears that no statement concerning overweight or underweight should be made without consideration of the maturity factor."

The author suggests that body build largely accounts for the differences in height-weight relationship between the groups. "A preliminary investigation of average hip and chest widths indicates that the various maturity groups differ as much in these measurements as in height and weight, and that, as in case of weight, the differences continue after cessation of growth."

HAROLD H. MITCHELL, M.D.
Long Island City, New York

RELIABILITY OF MEDICAL JUDGMENTS ON MALNUTRITION

By Mayhew Derryberry, Ph.D. 6 pp. U. S. Treasury Department, Public Health Service, Reprint No. 1909 from the Public Health Reports. Superintendent of Documents, Washington, D. C., 1938. 5c.

The data presented in this report were collected during a study of school health programs by the Research Division of the American Child Health Association. They indicate that physicians differ so greatly in their estimates of nutritional status of the same children that practical nutritional programs should not attempt such determinations but should be focused on correcting faulty food habits. The report also proposes that research workers concentrate on the construction of valid methods of determining nutritional status rather than making nutritional surveys which are of doubtful significance because of the inaccuracies of the estimates upon which their findings are based. E.McN.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

SCHOOL HEALTH

HOME AND SCHOOL COÖPERATION FOR THE HEALTH OF SCHOOL CHILDREN. Sub-committee of Joint Committee on Health Problems in Education of the N.E.A. and the A.N.A. National Education Association, 1201 Sixteenth Street, Northwest, Washington, D. C., 1937. 20c.

A report of the Joint Committee on Health Problems in Education of the N.E.A. and the A.M.A. with the coöperation of the National Congress of Parents and Teachers. It emphasizes the health of the whole child and suggests principles and practices which may guide homes and schools in effective coöperative effort toward optimal health for all school children.

OPEN AIR CLASSROOMS—EXTENDING THEIR BENEFITS TO ALL. Subcommittee of the Joint Committee on Health Problems in Education of the N.E.A. and the A.M.A. National Tuberculosis Association, 1937. May be secured from your state or local tuberculosis association.

This report of the Joint Committee on Health Problems in Education of the N.E.A. and the A.M.A. summarizes six features of the open-air class program which might be responsible for health improvement.

COMMON COLDS. Robert Olesen. Supplement No. 135 to the *Public Health Reports*, U. S. Public Health Service, Superintendent of Documents, Washington, D. C., 1938. 8 pp. 5c.

A practical and readable discussion of the so-called common cold—its symptoms, prevalance, cause, prevention, treatment, and complications. Useful for placing in the hands of lay people, or as reference material in schools. Emphasizes the necessity for segregation of infected persons; the value of rest in bed during the early stages; and the importance of avoiding excessively hot, dry indoor temperatures, as a preventive measure.

A PARENT LOOKS AT HOME WORK. Anna H. Hayes. *National Parent-Teacher*, November 1937, p. 10.

HOW MUCH HOMEWORK? Carleton Washburne. *Parents' Magazine*, November 1937, p. 16.

PRELIMINARY REPORT OF THE SUBCOMMITTEE OF THE EDUCATIONAL QUALIFICATIONS OF SCHOOL HEALTH EDUCATORS. The Committee on Professional Education of the American Public Health Association. *American Journal of Public Health*, July 1937, p. 711.

ALCOHOL AND NARCOTIC DRUGS. Haven Emerson. *Journal of National Education Association*, September 1937, p. 181.

Discusses the danger of alcohol and suggests a guide for its use applicable to different ages and situations.

STUDENT HEALTH SERVICES IN INSTITUTIONS OF HIGHER EDUCATION. James Frederick Rogers, M.D. Bulletin No. 7, Office of Education, U. S. Department of the Interior, 1937. 61pp. For sale by the Superintendent of Documents, Washington, D.C., 10c.

STUDENT INTERESTS AND NEEDS IN HYGIENE. J. F. Rogers, M.D. Bulletin No. 16, Office of Education, U. S. Department of the Interior. For sale by the Superintendent of Documents, Washington, D.C., 1937. 10c.

EVALUATION OF A RURAL SCHOOL HEALTH EDUCATION PROJECT. *Milbank Memorial Fund Quarterly*. Single copy 25c. (Two papers of a series on evaluation studies made of the school health program in Cattaraugus County.)

Ruth M. Strang, Ruth E. Grout, and Dorothy G. Wiehl. October 1937, p. 355.

A study of the comparative effectiveness of health education work by teachers having special help and in-service education and by teachers having no such help. The report lists the items selected for evaluating health instruction. The results show the value of in-service education.

C. A. Greenleaf, M.D., and Ruth E. Grout. April 1938, p. 156.

A study of the effectiveness of a rural school health program in improving the school environment during a six-year period. The study considers the factors that produced the changes and the results.

HEALTH PRACTICES AND TECHNIQUES. Vivian V. Drenckhahn and Ruth E. Grout. Chapter II, Newer Types of Instruction in Small Rural Schools. Bulletin of the Department of Rural Education, National Education Association, Washington, D.C., February 1938, p. 30. $1.

Nurses will be especially interested in the chapter on health practices and techniques, which presents suggestions for teaching health through real life experiences.

THE EFFECT OF POPULATION CHANGES ON AMERICAN EDUCATION. Educational Policies Commission, National Education Associa-

tion, Washington, D.C., 1938. 58pp. 50c.

An analysis of trends in population and their educational significance. The smaller school population offers an opportunity to enrich the program. Improvement of rural education has become a national necessity and the increasing proportion of adults suggests need for more adult education.

SCHOOL HEALTH SERVICE. Harold H. Mitchell, Chairman; Mary Chayer; C. C. Wilson. Eighth Annual Yearbook of American Public Health Association, 1937-1938. February 1938, p. 47.

This report of the Child Hygiene Section of the American Public Health Association includes the five principles of school health suggested by the American Academy of Pediatrics.

RURAL SCHOOL PLUMBING. Norman J. Radder. *The Nation's Schools,* March 1938, p. 52. 25c.

Practical suggestions for the installation of modern plumbing in rural schools.

ESSENTIALS FOR A WELL-ROUNDED SCHOOL-HEALTH PROGRAM. *The Child.* Children's Bureau, United States Department of Labor, March-April 1938, p. 205. For sale by the Superintendent of Documents, Washington, D.C., 10c.

REPORT OF THE ADVISORY COMMITTEE ON EDUCATION. (Floyd W. Reeves, Chairman and Director of Studies) 1938. 243pp. For sale by the Superintendent of Documents, Washington, D.C., 35c.

Many of the findings and recommendations contained in this report are of interest to school nurses.

SUGGESTED REGULATIONS FOR LIGHTING SIGHT-SAVING CLASSROOMS. Prepared by a Committee of the Ohio State Department of Education. *The Sight-Saving Review,* September 1937.

Specific and practical suggestions in regard to such factors in lighting as glare, diffusion, finish and colors of walls and ceiling, minimum level of illumination, and type and control of lighting. Applicable to all schools as well as sight-saving rooms.

WE AND OUR NEIGHBORS. Community Chests and Councils, 155 East 44 Street, New York, 1937. 80pp. Single copy 75c.

A subtitle informs us that this is "a welfare primer for junior and senior high school pupils and other students of social service." This comprehensive booklet gives a brief resume of the various social services common to modern communities.

PROCEEDINGS OF THE SECOND NATIONAL CONFERENCE ON COLLEGE HYGIENE, WASHINGTON, D.C. National Tuberculosis Association, 50 West 50 Street, New York, N.Y., June 1937. 112pp. $1.

SAFETY AND HEALTH OF THE SCHOOL CHILD. A Self-survey of School Conditions and Activities. James Frederick Rogers, M.D. Pamphlet No. 75, Office of Education, U. S. Department of the Interior. For sale by the Superintendent of Documents, Washington, D.C., 1937. 10c.

Contains questions covering all aspects of the health of the school child which can be used as a check list for self-survey of a school. It includes items on environmental control, mental conditions of the school which influence health, the physical health of the child, and the health of the teaching staff.

INFANT AND PRESCHOOL CHILD

STUTTERING. Herman M. Jahr. *Hygeia,* June 1938, p. 524.

Discusses some of the causes of stuttering, using case stories as illustrations.

THERE WAS A CROOKED MAN. F. Josephine Wagner. *Hygeia,* June 1938, p. 495.

Practical suggestions about factors leading to good postural development in children.

THE NURSERY SCHOOL: WHAT IS IT? WHAT ARE ITS PROBLEMS? Natalie Haskins Blumenthal. *Hygeia,* June 1938, p. 558.

The first of a series of articles on the nursery school. Traces the evolution of the nursery school in this country.

LOVE THEM AND TELL THEM SO. Helen Faw Mull. *Parents' Magazine,* July 1938, p. 17.

The story of parents who discovered that in their struggle not to spoil their children, they were impoverishing the children's emotional lives and giving them a sense of insecurity.

THE COST OF HABIT TRAINING. Len Chaloner. *Parents' Magazine,* August 1938, p. 17.

Points out the hazards of too much rigidity in child training.

DEVELOPMENTS IN FIELD OF EMERGENCY NURSERY SCHOOLS. Grace Langdon. *School Life,* Office of Education, U. S. Department of the Interior, March 1938, p. 242. $1 a year.

A discussion of the question, "To what extent is the emergency education program becoming a part of the permanent program?"

• The scholarship in health education offered annually to a nurse by the Massachusetts Institute of Technology was awarded for the year 1938-1939 to Pauline Christie of Wilmington, Del. Miss Christie is a graduate of Smith College and of the Presbyterian Hospital School of Nursing, New York City. For the past year she has been a member of the staff of the Wilmington Visiting Nurse Association.

• The educational radio program of the American Medical Association, "Your Health," was given an honor rating by the Institute for Education by Radio at its ninth annual conference at Columbus, Ohio. The programs given the first awards by the educational and radio experts were selected from those broadcast over the coast to coast networks of the National Broadcasting Company. This program has been broadcast for three seasons in dramatized form, and a new series is planned for 1938-1939.

• A report of a survey of health of college students and suggestions for a complete college health program were presented to the American Youth Commission of the American Council on Education at its May meeting in Washington. The survey, which covered 551 colleges and universities throughout the country, was conducted by Dr. Harold Diehl, dean of medical sciences, University of Minnesota, and Dr. Charles E. Shepard, director, Men Students' Health Service, Stanford University.

Earlier deficiencies and those associated with the college environment itself present two general classes of health problems affecting college students, the survey committee reported. To combat both problems, it was suggested, the student should be given a medical examination upon entering college and periodic examinations during succeeding years. In addition, there should be provision for emergency care of injuries and illness, where possible. It was recommended that students have access to medical advice in matters of physical and mental health not associated with any specific illness.

The problem of tuberculosis in college students was found to be particularly significant, inasmuch as results of studies indicate that one third of all students entering college are already infected, though only to a slight degree.

Four basic factors and their integrated development were given in the report as essential to the success of any college health program: a student health service for individuals, a campus public health service for the student body, classroom instruction in health matters, and physical education as a health activity and for correction of deficiencies.

• "Education for Tomorrow's America" will be the general theme of the program for American Education Week, November 6 to 12, inclusive, which is sponsored by the National Education Association, the United States Office of Education, and the American Legion.

• Sally Lucas Jean, R.N., executive secretary of the Health Section of the World Federation of Education Associations, is the new president of the Association of Women in Public Health.

• Many agencies in various parts of the country employing school nurses have adopted or are considering the adoption of the minimum qualifications for nurses appointed to school nursing positions published by the National Organization for Public Health Nursing in the February issue of PUBLIC HEALTH NURSING.

The Organization has recently received word from Dr. J. A. Olson, medical director of the public schools in Flint, Mich., that the Flint Board of Education has set these qualifications as a requirement for all nurses employed in the city schools.

• A progressive step in planning a coördinated school health program was taken in May when the Board of Education and the Department of Health in New York City organized a joint committee with representation from both departments and from lay groups. Although the Department of Health provides the medical and nursing service for the schools and the Board of Education supervises the general health program, this is the first permanent committee set up to coördinate action on health problems by the two departments. This coöperation is expected to result in less confusion, duplication, and wasted effort.

• The Thirty-third Annual Meeting of the Missouri State Nurses' Association and the Twenty-eighth Annual Meeting of the Missouri State League of Nursing Education will be held October 17, 18, and 19 in the Masonic Temple, Kirksville, Mo.

• The Child Study Association of America is observing its fiftieth anniversary during 1938. There will be a two-day conference on November 14 and 15 at the Hotel Roosevelt in New York City, in which "interested agencies will be invited to coöperate with the Association in summing up, for purposes of public information, gains made toward a better understanding of childhood and family life during the last half century." An institute will be held the two following days, November 16 and 17, at Child Study Headquarters, New York.

The Association serves primarily, according to the announcements of its anniversary program, "as interpreter between the family and specialized sources of knowledge, and creates a continuous flow of sound information into the community for the use of teachers, social workers, and public health nurses." It publishes a monthly journal, *Child Study*, as well as books and pamphlets on various phases of child life. Information regarding its activities can be secured from the Association at 221 West 57 Street, New York, N. Y.

• Approximately 300,000 students in American colleges and universities—or nearly 25 percent of the entire enrollment—are handicapped in their studies by serious visual defects, it was disclosed in a recent report of the Eye Health Committee of the American Student Health Association.

Surveys of students' vision reveal that the principal defects are astigmatism, farsightedness, and a lack of eye coördination, according to the report, prepared for the Committee by Anette M. Phelan, Ph.D., Associate in Health Education, National Society for the Prevention of Blindness.

Pointing out that the discovery and correction of visual defects is of vital concern to college administrators, the report urges a full ophthalmic examination for all students. It calls attention also to the fact that not only do students enter college with twice as many visual defects as their contemporaries who go into industry, but that one in six entering with presumably good vision will need glasses or treatment before graduation, and one in eleven will suffer a serious loss of visual acuity.

• Three subcommittees of the National Committee on Better Care for Mothers and Babies held meetings during July in Washington, D. C. These were the Subcommittee on Community Activities, which met on July 19; the Subcommittee on Professional Activities, on July 20; and the Executive Committee, on July 20. The time was chosen to take advantage of the fact that many committee members were in Washington to attend the National Health Conference.

• The Twenty-third National Recreation Congress will be held in Pittsburgh, Pa., October 3 to 7, at the William Penn Hotel. Approximately a thousand delegates from all over the United States, and some from other countries, are expected to attend. Information may be secured from T. E. Rivers, 315 Fourth Avenue, New York, N. Y.

• The General Federation of Women's Clubs passed the following resolution on syphilis control at its convention in Kansas City, Missouri, May 10-17, 1938:

WHEREAS, Syphilis is a recognized destroyer of mankind in the prime of life and is acquired in adolescence and early adult life or transmitted from a mother to her unborn child, and

WHEREAS, The effectiveness of present day measures for the control of syphilis has been demonstrated in a number of foreign countries and in one or two of the States of the Union, and

WHEREAS, The General Federation of Women's Clubs, has carried on a "Syphilis Education Program" for the past two years recognizing health examinations, which include blood tests for syphilis, as an indispensable part of all premarital and prenatal examinations, therefore be it

RESOLVED, That the General Federation of Women's Clubs in convention assembled, May 1938, support both federally and through the states the extension of facilities which would attack and conquer the plague of syphilis in this country.

This resolution was presented by Mrs. Carl W. Illig, Chairman of the Division of Public Health, and endorsed by Mrs. Clarence Fraim, Chairman of the Department of Public Welfare.

• The course in Survey of Eye Conditions is again being offered by New York University and Columbia University in coöperation with the Bureau of Services for the Blind, New York State Department of Social Welfare.

Ophthalmologists and technicians present a comprehensive body of knowledge on the eye, eye diseases, and conditions and treatment. Teachers, public health nurses, social workers, and others in allied fields will find this course intensely interesting because of the close interrelation of social, economic, educational, and health problems with eye conditions and diseases.

This course is offered in evening sessions at both universities. For detailed information address inquiries to the Office of the Secretary, Teachers College, Columbia University, 525 West 120 Street, New York, N. Y.; Helen C. Manzer, School of Education, New York University, Washington Square, New York, N. Y.; or Ruth B. McCoy, Director, Prevention of Blindness Service, New York State Department of Social Welfare, 205 East 42 Street, New York, N. Y.

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This plan has worked so well that a second high school in our city has installed the service this year. Visitors from nearby cities have come to observe the operation and the service. Our state board of health is interested in making a movie of the program in operation.

LULU V. CLINE, R.N.
Director of Health,
Department of Health Education,
School City of South Bend, Indiana

NOTE: Special credit should be given to Max Bullock, director of physical education, for the details of the plan and for his untiring efforts to make it a success.

Our Readers Say . . .

THIS COLUMN is intended to serve as a forum for the expression of reader opinion. Only signed letters will be published, although the signature will not be used except with the writer's permission. The National Organization for Public Health Nursing is not responsible for opinions expressed on this page.

THE NURSE IN THE NURSERY SCHOOL

TO THE EDITOR:

I am working as a nurse in a nursery school and am interested in the future of the nurse in nursery schools. I find very little information about the nurse in nursery schools in PUBLIC HEALTH NURSING. Do you have any news or data on this subject which you might send me? These are some of the questions which come up in our work:

1. Is the nurse an indispensable part of the nursery school, or will the teacher be able to carry on the inspections of children, and so supplement her. This has been stated.

2. Is the nurse who carries on public health work qualified to do parent-education work? To what degree?

FAY W. ATCHESON, R.N.
San Francisco, California

FROM A NURSERY SCHOOL SPECIALIST

It does seem to me extremely important that nursery school children be examined every morning by a thoroughly competent person. In our school we do not rely on the teacher to make this inspection but have the services of a public health nurse every morning. However, we do give the girls who are preparing to be nursery school teachers some instruction in how to inspect a child and how to take care of first-aid situations that may arise throughout the day. This we think is necessary because so many will go to nursery schools where they will not have the services of a nurse every day. Of course, I believe a nurse who prepares herself to be a nursery school teacher has an especially happy combination of qualifications.

As for the second question [see letter from Fay W. Atcheson above] it seems to me that any public health nurse who is worth her salt is doing parent education, within certain limits, of course. But *anyone* who is doing parent education can only do it to the degree that she is qualified to do it.

If a nurse knows a good deal about the physical care of children and how to live healthfully, she teaches the parents that. And if she doesn't know anything about child training and has no understanding of personality growth, then she ought to keep off that subject. However, it seems to me that the public health nurse today, especially if she is doing *anything* in child health, must know something about mental health—which means she must know something she can give to parents that will help them in promoting the child's mental health.

Certainly many a public health nurse is not qualified today to do an all-round piece of work in parent education, but we mustn't forget that teaching mothers about the physical care of their babies is one aspect of parent education. Let us, as public health nurses, do that and do that well; but let us do something more.

WINIFRED RAND, R.N.
Merrill-Palmer School,
Detroit, Michigan

TEACHING THE TEACHERS

I am writing to express my gratitude for the article in the March 1938 magazine, "The School Nurse as a Health Supervisor." [By Mabel K. Rugen.] I am always looking for material along this line and find so little of it. We school nurses in California are doing more and more health supervision work and are very grateful for anything that may appear along this line from time to time.

Teaching health is a difficult subject for the teachers, as no definite preparation is given to them during their training. Why are not healthful living activities stressed as a means of educational preparation for the teacher so that she may better teach this difficult subject? Teachers are all aware that a child must be healthy before he can properly fit into a classroom situation, yet are at a loss when it comes to developing units that include interesting material for the children.

Have you had any expression along this line from other health supervisors?

I read the PUBLIC HEALTH NURSING journal each month and find it very helpful and am often able to use some of the material for teachers' meetings or mothers' group activities.

MARGARET RIASSETTO, R.N.
Rural Schools Health Supervisor,
Merced, California